

FLORIDA DEPARTMENT OF HEALTH

AGENCY STRATEGIC PLAN

IMPLEMENTATION PLAN

2012-2015

MISSION

To protect, promote and improve the health of all people in Florida through integrated state, county, and community efforts.



Rick Scott

GOVERNOR

John Armstrong, MD, FACS

STATE SURGEON GENERAL
AND SECRETARY OF HEALTH

Version 1.2 June 2013

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ACKNOWLEDGMENTS

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EXECUTIVE SUMMARY

INTRODUCTION

THIS STRATEGIC PLAN PROVIDES A UNIFIED VISION AND FRAMEWORK FOR ACTION FOR THE FLORIDA DEPARTMENT OF HEALTH (DOH) OVER THE NEXT FOUR YEARS. As part of a larger performance management system, the Agency Strategic Plan Implementation Plan allows us to identify the critical issues that must be addressed to protect, promote and improve the health of Floridians. The Agency Strategic Plan Implementation Plan ensures alignment of the agency priorities to the state's public health system priorities, established in the State Health Improvement Plan (SHIP). The objectives in the plan will be used to measure the progress toward the goals. We will evaluate and update the plan regularly to address the new challenges

THE STRATEGIC PLANNING PROCESS

DOH's Performance Management Council, made up of central office program directors and CHD administrators and directors, oversaw the development of the Agency Strategic Plan Implementation Plan. The Council reviewed the key findings from the State Health Assessment (**Appendix A**) and had a facilitated discussion of agency strengths, weaknesses, opportunities and threats (SWOT analysis) based on the findings (**Appendix B**).

State Surgeon General John Armstrong met with the Performance Management Council to discuss revising the agency mission, vision and values. The Council drafted a revision and a survey was sent to CHD administrators and directors to solicit input from their staff. The Council discussed the CHD suggestions and revised the draft. Dr. Armstrong then solicited more input from central office staff through various meetings throughout the agency before unveiling the final mission, vision and values.

Council members then used the SWOT analysis and the agency mission, vision and values to choose strategic issue areas and agency goals. After a two-day face-to-face meeting, members arrived at the final strategic issue areas: health protection and promotion, financial and business excellence, service to customers and community, and workforce development. Staff from the Division of Public Health Statistics and Performance Management worked with DOH program managers and their staff to write and revise strategies and objectives for each goal area, which were then routed back to the Council and executive leadership for comment and approval.

THE AGENCY STRATEGIC PLAN

The following **strategy map** provides an overview of the key components of the Agency Strategic Plan Implementation Plan.

STRATEGY MAP

STRATEGIC ISSUE AREAS

STRATEGIES

KEY ACTIVITIES

HEALTH PROTECTION AND PROMOTION

GOALS:

- Protect the population from health threats
- Reduce chronic disease morbidity and mortality
- Improve maternal and child health

- Prevent and control infectious disease
- Prevent illness, injury and death related to environmental factors
- Minimize loss of life, illness, and injury from disasters
- Prevent and reduce intentional and unintentional injuries
- Increase the number of adults and children who are at a healthy weight
- Reduce illness, disability, and death related to tobacco use
- Reduce infant mortality
- Meet special health care needs of children

- Advance programs including Florida SHOTS, Vaccine for Children, Vaccine Preventable Disease Surveillance
- Implement new system of care for TB
- Implement Public Health and Health Care Preparedness Strategic Plan
- Use of evidenced-based guidelines to assess overweight and obesity and establish principles of safe and effective weight loss
- Promote model policies and practices about healthy foods
- Implement Tobacco Free Florida Campaign
- Use innovative oral health care delivery practice methods
- Implement Healthy Start program redesign
- Implement new care coordination system for the CMS Network

FINANCIAL AND BUSINESS EXCELLENCE

GOALS:

- Improve efficiency and effectiveness
- Maximize funding to accomplish public health mission
- Promote a culture of organizational excellence
- Optimize communications

- Use information technology and systems to support disease prevention, intervention and epidemiological activities
- Use information technology and systems to improve business practices
- Adopt certified electronic health record software
- Connect agency providers and electronic health record systems in a network
- Implement tools, processes, methods that support accountability and transparency in management systems
- Maximize Medicaid and third party revenue to help retain CHD and CMS providers retain necessary infrastructure
- Review and update fee policies and fee schedules
- Collect, track and use performance data to inform business decisions
- Maintain a sustainable performance management framework for the agency
- Develop, implement and sustain quality improvement processes
- Develop, implement, improve internal and external communication strategies and plans

- Implement agency Accreditation Plan
- Implement Information Technology Strategic Plan
- Implement Electronic Health Record Development Plan
- Implement Health Information Exchange Implementation Plan
- Implement the CHD Health Management System Billing Redesign Project and third-party billing administrator function for CMS
- Expand videoconferencing capabilities and e-mail solution
- Implement electronic business practices
- Establish managed care technical assistance group
- Analyze fee structures and policies
- Develop and implement an agency Quality Improvement Plan

SERVICE TO CUSTOMERS AND COMMUNITY

GOALS:

- Promote an integrated public health system
- Assure access to care
- Expediently license health care professionals who meet statutorily mandated standards of competency

- Link health improvement planning at state and local levels
- Integrate planning and assessment processes
- Support local efforts to revitalize communities
- Increase access to care for underserved populations
- Provide access to culturally and linguistically competent care
- Provide an efficient licensure process that meets statutory requirements

- Make available community health improvement plan resources
- Include public health component in community planning processes
- Assess Florida's health care access resources and needs
- Develop CLAS self-assessment tool that can be used across many provider settings
- Deploy online initial licensure applications

WORKFORCE DEVELOPMENT

GOALS:

- Attract, recruit, retain a competent credentialed workforce
- Ensure partnerships, systems and processes to support the future workforce

- Implement a competency-based framework for recruitment and training
- Provide trainings and resources that develop current employees
- Develop, sustain and improve an agency Workforce Development Plan

- Adopt agency core competency framework
- Implement enhanced learning management system
- Develop certificate programs in areas of core competencies
- Create, deploy DOH lifelong learning opportunities web site
- Develop mentoring and internship programs
- Partner with universities to ensure learning opportunities
- Implement succession planning

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INTRODUCTION

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The Agency Strategic Plan Implementation Plan ensures alignment of the agency priorities to the state's public health system priorities, established in the State Health Improvement Plan (SHIP).

WHO WE ARE

THE DEPARTMENT OF HEALTH IS FLORIDA'S STATE AGENCY DEDICATED TO PROTECTING, PROMOTING AND IMPROVING THE HEALTH OF ALL PEOPLE IN FLORIDA THROUGH INTEGRATED STATE, COUNTY AND COMMUNITY EFFORTS. Established by the Florida Legislature in 1996, the department traces its roots to the creation of the Florida State Board of Health in 1889. The department is an executive branch agency, established in section 20.43, *F.S.* We are led by a State Surgeon General, who serves as the State Health Officer and is directly appointed by Florida's Governor and confirmed by Florida's Senate. Three deputy secretaries oversee all of our business and programmatic operations.

DOH is an integrated agency composed of a state health office (central office) in Tallahassee; Florida's 67 county health departments (CHDs); 22 Children's Medical Services (CMS) area offices; 12 Medical Quality Assurance regional offices; nine Disability Determinations regional offices; and four public health laboratories. Partnerships with local county governments provide facilities for the 67 CHDs. These 67 CHDs have a total of 255 sites throughout the state, providing a variety of services, and ranging from small to large in location size. Unlike many other states where each local health department is a separate entity, Florida's integrated centralized system allows for standardized care and services across the state. Both statewide and local public health functions are addressed through this organizational structure.

We are accountable to the state legislature, the Executive Office of the Governor, all residents and visitors in the state, and the federal government. The Governor and the legislature determine departmental services, associated funding, and delivery mechanisms. Annually, the state legislature passes a budget, approved by the Governor, and creates or amends laws that direct the department's actions. The department's total budget for fiscal year (FY) 2011–2012 is \$2,857,264,986.

Most of the department's employees are full-time state employees or employees working on an hourly basis. We also use a variety of contract employees, some of whom are funded through grants or other external sources. In 2011, the department employed 16,985 full time state employees. Of this number, about 10% are central office staff who work in Tallahassee and the remaining 90% work in CHDs throughout the state.

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WHAT WE DO

THE DEPARTMENT MONITORS THE HEALTH STATUS OF FLORIDIANS; IDENTIFIES, DIAGNOSES, INVESTIGATES AND TREATS HEALTH PROBLEMS; AND MOBILIZES LOCAL COMMUNITIES TO ADDRESS HEALTH-RELATED ISSUES. We formulate policies and plans that support public health goals, enforce laws and regulations necessary to protect the public's health, link people to needed health care services, and provide necessary local services. Our staff license and regulate health care practitioners and provide medical disability determinations. In addition, we have statewide and local responsibilities in disaster preparedness and response, and maintain a large base of equipment, vehicles, mobile medical clinics, and communications infrastructure for all hazards. We provide specialized assistance to pregnant women, infants and children with special health care needs. We house all vital records and participate in the exchange of health-related data with state and national agencies.

CHDs provide communicable disease control, personal and environmental health services. In communicable disease, services include HIV/AIDS testing, treatment and prevention; childhood immunizations; sexually transmitted diseases testing and treatment; epidemiology; tuberculosis testing and treatment; chronic disease prevention and treatment; and health promotion counseling and education. In personal health, services include basic medical care services and treatments; Healthy Start; child health services; family planning; Women, Infants and Children (WIC); and dental health. Our environmental health programs regulate onsite sewage systems, monitor drinking water and group bathing facilities and investigate sanitary hazards.

Through our network of CHDs, CMS clinics and a number of community-based clinics across the state, we provide direct clinical and case management services to a variety of clients, including the medically indigent and those who do not have health insurance, using a sliding scale to assess fees. Our clinical providers are attentive to the needs of special populations, such as older adults, women, children, and disabled persons, and are committed to providing linguistically and culturally competent services to all clients.

Effective public health requires organized community efforts. We collaborate in health improvement planning, share information, and mobilize for emergency health response with a robust network of partnerships. We also work in partnership with a network of 11 local health planning agencies to collect and analyze local health data, identify resources, and collaborate with other community partners to improve access, affordability and quality of care, and create strategic approaches to address local health priorities.

MEETING THE CHALLENGES OF THE FUTURE

THE SCOPE AND COMPLEXITY OF CURRENT HEALTH PROBLEMS PRESENT FORMIDABLE CHALLENGES FOR FLORIDA.

A number of issues confront the state in meeting the health needs of its residents and visitors. These include the growth and diversity of Florida's population; the ongoing threat of infectious diseases, such as influenza, HIV/AIDS, and tuberculosis; the large number of substance abusers, including children and adults who use tobacco and consume alcohol; and the ever-present threat of natural or man-made disasters. Also of critical importance is addressing the wide disparities in health status, with minority populations bearing a disproportionate burden of disease. We use community-focused strategies to provide the tools, planning support and policy direction communities need in order to address the challenges presented by a broad spectrum of public health issues.

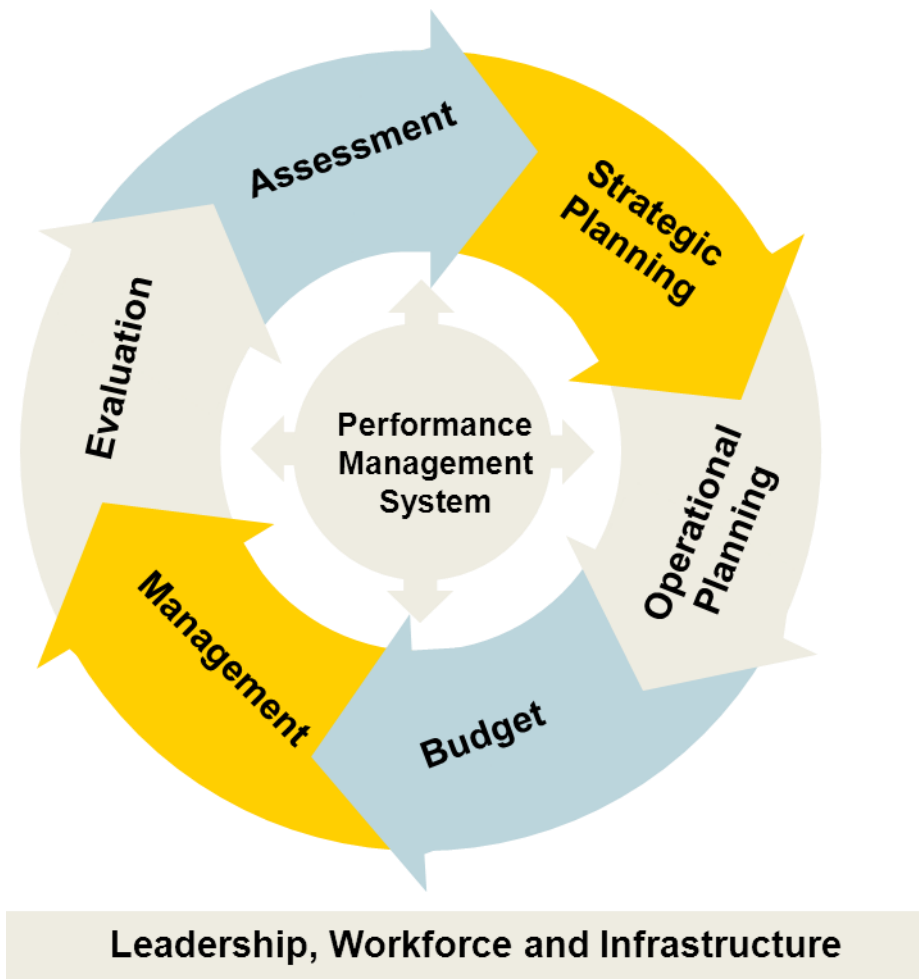
The economic environment continues to affect public health in Florida. One ongoing challenge is the ever-increasing demand for public health services in the face of limited resources. DOH's performance management system (see discussion below) is designed to help us meet this challenge by focusing and unifying our efforts internally and with our public health system partners. Because of rapid changes in the environment—including demands for increased accountability for public agencies, rapid technological and medical advances, escalating health care costs, and managed care—our agency must continually evolve to protect, promote and improve the health of Floridians.

LOOKING TO THE FUTURE: THE DOH PERFORMANCE MANAGEMENT SYSTEM

Due to its size, scope and structure, DOH has a need to better integrate existing components of state and county performance management processes into a more comprehensively aligned, statewide system. We are currently working to build such a system. In May 2011, the State Surgeon General convened a DOH Performance Management Advisory Council, with membership representative of both central office programs and CHDs. He charged this council with developing and implementing a plan to build and sustain the DOH Performance Management System.

DOH is currently conducting state and local health improvement planning to strategically identify health priorities to improve the health of all Floridians. We have completed the state health assessment and state health improvement planning processes and soon all CHDs will have aligned community health assessment and community health improvement plans. As depicted in the image following, the Agency Strategic Plan is a key component of the larger system. This statewide performance management system will be the cornerstone of the department's organizational culture of accountability and performance excellence.

Florida Department of Health Performance Management System



THE STRATEGIC PLANNING PROCESS

The Agency Strategic Plan Implementation Plan was created by key leaders at DOH, including managers and program and field staff. DOH formed a Performance Management Advisory Council (the Council) in May of 2011, made up of central office division directors and CHD administrators and directors, to oversee the formation of an integrated performance management system and make recommendations about tools and methods that integrate performance management into sustainable business practices. On August 8, 2012, the Council was designated as the body to oversee the development of the Agency Strategic Plan Implementation Plan. See the following table for the meeting dates and topics.

PERFORMANCE MANAGEMENT COUNCIL AGENCY STRATEGIC PLAN

MEETING SCHEDULE

MEETING DATE	MEETING TOPIC
Aug. 8, 2012	Establish Performance Management Advisory Council as official oversight body for the agency strategic plan and use Florida State Health Improvement Plan (SHIP) strategic issue areas as framework for Agency Strategic Plan
Aug. 16, 2012	Establish timeline for strategic plan development
Aug. 22, 2012	Discuss four state assessments and the DOH strengths, weaknesses, opportunities and threats that emerge from them
Aug. 23, 2012	Develop objectives for Agency Strategic Plan
Aug. 27, 2012	Reconsider use of SHIP strategic issue areas and move toward a Balanced Scorecard framework
Aug. 30, 2012	Brainstorm state agency vision and values with State Surgeon General John Armstrong
Sept. 5, 2012	Review and adopt the balanced scorecard approach for the strategic plan. Suggest ways to tailor approach to DOH
Sept. 10, 2012	Review comments from county health departments and recommend DOH mission, vision and values
Sept.12, 2012 (day long face-to-face meeting)	Discuss and modify draft Agency Strategic Plan
Sept.13, 2012 (day long face-to-face meeting)	Discuss and modify draft Agency Strategic Plan
Sept. 26, 2012	Review final draft of Agency Strategic Plan goals and objectives

In April of 2012, DOH released the SHIP, a statewide plan for public health partners and stakeholders to improve the health of Floridians. The SHIP was based on four state assessments:

The **STATE HEALTH STATUS ASSESSMENT** identifies priority health and quality of life issues. Questions answered here include, "How healthy are our residents?" and "What does the health status of our state look like?"

The **STATE PUBLIC HEALTH SYSTEM ASSESSMENT** focuses on all of the organizations and entities that contribute to the public's health. The Public Health System Assessment answers the questions, "What are the components, activities, competencies and capacities of our public health system?" and "How are the Essential Services being provided to our state?"

The **STATE THEMES AND STRENGTHS ASSESSMENT** identifies the important health issues as perceived by state residents. The assessment answers the questions: "What is important to the state?", "How is quality of life perceived in the state?" and "What assets exist that can be used to improve health in the state?"

The **STATE FORCES OF CHANGE ASSESSMENT** determines forces that impact the way the system operates, including legislation, funding shifts, technology or other impending changes that may affect state residents or the state system. Threats or opportunities generated by these occurrences should be considered. It answers the questions, "What is occurring or might occur that affects the health of our state?" and "What specific threats or opportunities are generated by these occurrences?"

Subject matter experts from across a diverse group of partners conducted the four types of assessments (see **Appendix A** for more information on how and with whom each assessment was conducted). Individually, the assessments yielded in-depth analyses of factors and forces that impact population health. Taken together, the assessment findings contribute to a comprehensive view of health and quality of life in Florida. The four assessments were compiled to make the State Health Assessment.

The Council reviewed the key findings from the State Health Assessment and had a facilitated discussion of agency strengths, weaknesses, opportunities and threats (SWOT analysis) based on the findings (see **Appendix B** for the outcome of this discussion).

State Surgeon General John Armstrong met with the Council to discuss revisiting and revising the agency mission, vision and values. The Council drafted a revision and a survey was sent to CHD administrators and directors to solicit input from their staff. The Council reviewed and discussed the CHD suggestions and revised the draft. Dr. Armstrong then solicited more input from central office staff through various meetings throughout the agency before unveiling the final mission, vision and values.

Council members then used the SWOT analysis and the agency mission, vision and values to choose strategic issue areas and agency goals, reformulating and refining them over a series of meetings. They ensured that the Agency Strategic Plan supported and aligned with the goals, strategies and objectives in the SHIP (see **Appendix C** for an alignment crosswalk table). After a two-day face-to-face meeting, Council members arrived at the final strategic issue areas: health protection and promotion, financial and business excellence, service to customers and community, and workforce development. Staff from the Division of Public Health Statistics and Performance Management worked with DOH program managers and their staff to write and revise strategies and objectives for each goal area, which were then routed back to the Council and executive leadership for comment and approval.

Each county health department then aligned their own strategic objectives to the Agency Strategic Plan Implementation Plan strategies (see **Appendix D** for county health department alignment documents).

The **strategy map** that follows shows the final strategic issue areas, strategies and key activities. The plan that follows the strategy map includes the strategic issue areas and strategies, and also provides measurable objectives for each.

STRATEGY MAP

STRATEGIC ISSUE AREAS

STRATEGIES

KEY ACTIVITIES

HEALTH PROTECTION AND PROMOTION

GOALS:

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STRATEGIC ISSUE AREA: HEALTH PROTECTION AND PROMOTION

GOALS, STRATEGIES AND OBJECTIVES

GOAL 1.1 PROTECT THE POPULATION FROM HEALTH THREATS.

STRATEGY 1.1.1 PREVENT AND CONTROL INFECTIOUS DISEASE.

- Objective 1.1.1A By Dec. 31, 2015, increase the percentage of two-year-olds who are fully immunized from 86.6% (2011) to 90%.
- Objective 1.1.1B By Dec. 31, 2015, reduce the bacterial STD case rate among females 15-34 years of age from 2627.3 per 100,000 (2010) to 2605 per 100,000.
- Objective 1.1.1C By Dec. 31, 2015, reduce the TB case rate from 4.4 per 100,000 (2010) to 3.5 per 100,000.
- Objective 1.1.1D By Dec. 31, 2015, increase the number of identified foodborne disease outbreaks from 2.69 (2011) per million population to 3.09 per million population.
- Objective 1.1.1E By Dec. 31, 2015, reduce the AIDS case rate per 100,000 from 18.2 (2011) to 17.2.
- Objective 1.1.1F By Dec. 31, 2015, reduce the number of new HIV infections in Florida from 4,577 (2009) per year to 2,778 per year with particular focus on the elimination of racial and ethnic disparities in new HIV infections.
- Objective 1.1.1G By Dec. 31, 2013, increase the number of selected reportable disease cases of public health significance reported from CHDs within 14 days of notification to greater than 75%.
- Objective 1.1.1H By March 31, 2013, conduct a CHD consortia-level assessment of the current tuberculosis control program and recommend program priorities and resource allocation.
- Objective 1.1.1I By Dec. 31, 2013, implement a new system of care for the statewide tuberculosis program.
- Objective 1.1.1J By Dec. 31, 2015, increase by 10% the proportion of reports of selected reportable diseases for which initial public health control measure(s) were initiated within the appropriate time frame (as defined by the standard established in the CHD Snapshot Guidance for Epidemiology Measures document).
- Objective 1.1.1K By Dec. 31, 2014, develop a plan that enables interoperability across appropriate disease surveillance systems.

See also STRATEGY 2.1.3, OBJECTIVES 2.1.3A, B, and C

STRATEGY 1.1.2 PREVENT AND REDUCE ILLNESS, INJURY AND DEATH RELATED TO ENVIRONMENTAL FACTORS.

- Objective 1.1.2A By Sept. 30, 2013, and annually ensure that 90% of illness outbreaks associated with a regulated facility have an environmental assessment or inspection done within 48 hours of initial outbreak report.
- Objective 1.1.2B By Dec. 31, 2014, 100% of Florida counties will complete the Environmental Public Health Performance assessment, use data to determine gaps and opportunities, and create health plans.

STRATEGIC ISSUE AREA: HEALTH PROTECTION AND PROMOTION

STRATEGY 1.1.3	MINIMIZE LOSS OF LIFE, ILLNESS, AND INJURY FROM NATURAL OR MAN-MADE DISASTERS.
Objective 1.1.3A	By Dec. 31, 2013, the score for each CHD that meets or exceeds the CHD preparedness expectations shall be at least 4.75.
STRATEGY 1.1.4	PREVENT AND REDUCE INTENTIONAL AND UNINTENTIONAL INJURIES.
Objective 1.1.4A	By Dec. 31, 2015, reduce the rate of deaths from all causes of external injury among Florida resident children ages 0–14 from 9.0 per 100,000 to 7.6 per 100,000 in those Florida counties with existing state-local injury prevention partnerships with their local Safe Kids chapter or coalition.* *Includes Bay, Marion, Osceola, Lake, Sumter, Okaloosa, Santa Rosa, Leon, Broward, Miami-Dade, Tampa, Lee, Collier, Alachua, Bradford, Columbia, Dixie, Gilchrist, Levy, Suwannee, Union, Orange, Baker, Clay, Duval, Nassau, Putman, St. Johns, Palm Beach, Seminole, Pasco, Pinellas, Polk, Manatee, Sarasota, Volusia, Flagler.
Objective 1.1.4B	By Dec. 31, 2015, decrease the rate of death from falls among persons aged 65 and over in Florida from 59.7 per 100,000 (2011) to 50.
Objective 1.1.4C	By Dec. 31, 2015, decrease the rate of death from unintentional injury in Florida from 40.2 per 100,000 (2011) to 38.
GOAL 1.2	REDUCE CHRONIC DISEASE MORBIDITY AND MORTALITY.
STRATEGY 1.2.1	INCREASE THE PROPORTION OF ADULTS AND CHILDREN WHO ARE AT A HEALTHY WEIGHT.
Objective 1.2.1A	By Dec. 31, 2015, increase the percentage of adults who have a healthy weight from 34.9% (2010) to 40.0% (healthy weight is BMI of 18.5 to 24.9).
Objective 1.2.1B	By Dec. 31, 2015, decrease the percentage of WIC children aged 2 and above who are overweight or at risk of overweight from 29.5% (2010) to 28.5%.
Objective 1.2.1C	By Dec. 31, 2015, increase the percentage of students in grades 1,3, and 6 who are identified as being at normal weight from 60% (2011-2012) to 63%.
Objective 1.2.1D	By Dec. 31, 2015, decrease the percentage of students in grades 6-12 reporting BMI at or above the 95 th percentile from 11.6% (2010) to 10%.
STRATEGY 1.2.2	REDUCE ILLNESS, DISABILITY, AND DEATH RELATED TO TOBACCO USE AND SECONDHAND SMOKE EXPOSURE.
Objective 1.2.2A	By Dec. 31, 2015, reduce current smoking rates among adults from 17.1% (2010) to 14.5%.

STRATEGIC ISSUE AREA: HEALTH PROTECTION AND PROMOTION

Objective 1.2.2B	By Dec. 31, 2015, reduce current cigarette use among youth, ages 11-17, from 8.3% (2010) to 7.5%.
Objective 1.2.2C	By Dec. 31, 2015, reduce the percentage of adults who were exposed to secondhand smoke at home during the past 7 days from 8.6% (2010) to 7.7%.
Objective 1.2.2D	By Dec. 31, 2015, reduce the percentage of youth, ages 11-17, who were exposed to secondhand smoke in a room or car during the past 7 days from 50.3% (2010) to 45.3%.
Objective 1.2.2E	By June 30, 2015, reduce the percentage of youth, ages 11-17, who use tobacco products *other than cigarettes from 14.1% (2010 Florida Youth Tobacco Survey) to 12.7%. <i>*Other tobacco products include smokeless tobacco, snus, and cigars</i>
Objective 1.2.2F	By June 30, 2015, reduce the percentage of adults who use tobacco products *other than cigarettes from 5.6% (2008 BRFSS) to 4.8%. <i>*Other tobacco products include smokeless tobacco, snus, and cigars</i>

GOAL 1.3 IMPROVE MATERNAL AND CHILD HEALTH.

STRATEGY 1.3.1 REDUCE INFANT MORTALITY.

Objective 1.3.1A	By Dec. 31, 2015, reduce the infant mortality rate from 6.4 (2011) per 1,000 live births to 6.1.
Objective 1.3.1B	By Dec. 31, 2015, reduce the black infant mortality rate from 12.0 (2011) per 1,000 live births to 10.9.

STRATEGY 1.3.2 MEET SPECIAL HEALTH CARE NEEDS OF CHILDREN.

Objective 1.3.2A	By June 30, 2013, 100% of CMS area offices will collaborate with Department of Children and Families in the provision of care coordination services for children in out-of-home care who meet the clinical eligibility criteria for the CMS Network.
Objective 1.3.2B	By Dec. 31, 2015, increase the percentage of 8-year-old Medicaid-eligible children who have received dental sealants on their molar teeth from 14% (2010) to 17%.

STRATEGIC ISSUE AREA: FINANCIAL AND BUSINESS EXCELLENCE

GOALS, STRATEGIES AND OBJECTIVES

GOAL 2.1 IMPROVE EFFICIENCY AND EFFECTIVENESS.

STRATEGY 2.1.1 USE INFORMATION TECHNOLOGY AND SYSTEMS TO EFFICIENTLY SUPPORT DISEASE PREVENTION, INTERVENTION AND EPIDEMIOLOGICAL ACTIVITIES.

See also GOAL 1.1. These internal capacities support protecting the population from health threats.

- Objective 2.1.1A By Jan. 1, 2013, increase the percentage of reportable disease case reports where DOH received electronically submitted laboratory reports to 65%.
- Objective 2.1.1B By Dec. 31, 2013, increase the number of hospitals and urgent care centers submitting electronic information used for syndromic surveillance to DOH from 170 to 185.
- Objective 2.1.1C By Jan. 1, 2015, DOH will be using the statewide HIE to support public health case reporting and epidemiological case follow-up.
- Objective 2.1.1D By Dec. 31, 2014, implement an electronic system for new applications and renewals for applicable environmental health program permits and licenses.

STRATEGY 2.1.2 USE PUBLIC HEALTH INFORMATION TECHNOLOGY AND SYSTEMS TO EFFICIENTLY IMPROVE BUSINESS PRACTICES.

- Objective 2.1.2A By Jan. 1, 2013, establish a baseline internal video capability that extends video calls to the desktop.
- Objective 2.1.2B By March 31, 2014, extend video calls to desktops while limiting the need for intermediate video infrastructure.
- Objective 2.1.2C By July 1, 2015, implement an agency-wide video to maximize utilization and return on investment.
- Objective 2.1.2D By June 30, 2014, implement agency-wide communications cloud services to fully leverage scalability and interoperability with email, office suite and collaboration tools.
- Objective 2.1.2E By June 30, 2013, implement a DOH Information Technology Strategic Plan in alignment with the SHIP and the Agency Strategic Plan with comprehensive information technology goals to address clinical and administrative applications.

STRATEGY 2.1.3 ADOPT CERTIFIED ELECTRONIC HEALTH RECORD SOFTWARE.

- Objective 2.1.2A By Nov. 30, 2012, DOH will complete certification of the Health Management System (HMS) electronic health record for CHDs.
- Objective 2.1.2B By June 30, 2013, all CHD clinical sites will have adopted the DOH certified Electronic Health Record.
- Objective 2.1.2C By April 30, 2013, CMS will have implemented a third-party billing administrator function to automate billing functions.

STRATEGIC ISSUE AREA: FINANCIAL AND BUSINESS EXCELLENCE

- STRATEGY 2.1.4** **CONNECT AGENCY PROVIDERS AND ELECTRONIC HEALTH RECORD SYSTEMS IN A NETWORK THAT CONSISTS OF A STATE-LEVEL HEALTH INFORMATION EXCHANGE (HIE), DIRECT SECURED MESSAGING AND LOCAL HEALTH INFORMATION EXCHANGES AND GATEWAYS.**
- Objective 2.1.4A By June 30, 2013, DOH will complete statewide implementation of the Master Patient Index system.
- Objective 2.1.4B By Dec. 31, 2013, DOH will begin the pilot phase of implementation of the HIE, which consists of a statewide Master Patient Look-up function across all CHDs and public health surveillance systems and the ability to exchange patient clinical data both internally and with external community partners.
- STRATEGY 2.1.5** **IMPLEMENT TOOLS, PROCESSES AND METHODS THAT SUPPORT ACCOUNTABILITY AND PROVIDE TRANSPARENCY IN DOH ADMINISTRATIVE MANAGEMENT SYSTEMS.**
- Objective 2.1.5A By March 31, 2013, develop an agency-wide process for systematically assessing and prioritizing administrative management process improvements.
- Objective 2.1.5B By March 31, 2014, implement barcode scanning for nurse issuance pharmaceuticals to increase inventory accuracy.
- Objective 2.1.5C By Oct. 31, 2013, develop an automated budget reporting system for DOH that provides transparency across all central office budgets.
- Objective 2.1.5D By March 31, 2013, develop remaining modules for the Public Health Financial Management training program.
- Objective 2.1.5E By Oct. 31, 2014, implement an online travel system.
- Objective 2.1.5F By May 31, 2013, implement an electronic review of contracts and grants.
- Objective 2.1.5G By Jan. 31, 2014, implement an automated system for completion of employee performance appraisals.

STRATEGIC ISSUE AREA: FINANCIAL AND BUSINESS EXCELLENCE

GOAL 2.2 MAXIMIZE FUNDING TO ACCOMPLISH THE PUBLIC HEALTH MISSION.

STRATEGY 2.2.1 MAXIMIZE MEDICAID AND OTHER THIRD PARTY REVENUE TO HELP CHDS AND CMS PROVIDERS RETAIN THE INFRASTRUCTURE NECESSARY TO MEET THE PUBLIC HEALTH NEEDS OF THE COMMUNITIES THEY SERVE.

- Objective 2.2.1A By July 1, 2013, implement a revised Medicaid reduction methodology for cost-based providers in the General Appropriation Act and apply DOH efficiency standards to CHD rates.
- Objective 2.2.1B By Dec. 1, 2015, implement the CHD Health Management System Billing Redesign Project to automate all major billing functions and establish 100% electronic interaction with health care plans.
- Objective 2.2.1C By Sept. 1, 2013, implement a third-party billing administrator function to automate claims payment and other programmatic support services for CMS.

STRATEGY 2.2.2 REVIEW AND UPDATE FEE POLICIES AND FEE SCHEDULES.

- Objective 2.2.2A By Dec. 1, 2013, and annually, complete process to analyze all state and local fees to ensure alignment with actual program costs.
- Objective 2.2.2B By March 1, 2013, develop a standard methodology for calculating the cost of specific medical and dental procedures weighted by relative value units for the major CHD clinical programs.

GOAL 2.3 PROMOTE A CULTURE OF ORGANIZATIONAL EXCELLENCE.

STRATEGY 2.3.1 COLLECT, TRACK AND USE PERFORMANCE DATA TO INFORM BUSINESS DECISIONS AND CONTINUOUSLY IMPROVE.

- Objective 2.3.1A By Dec. 31, 2013, DOH's performance management data system will be operational.
- Objective 2.3.1B By June 30, 2014, DOH will be accredited by the Public Health Accreditation Board.
- Objective 2.3.1C By Dec. 31, 2013, complete a comprehensive management review of 100% of CMS area offices to ensure continuous improvement efforts related to the processes and functions of the CMS Network.

STRATEGY 2.3.2 MAINTAIN A SUSTAINABLE PERFORMANCE MANAGEMENT FRAMEWORK.

- Objective 2.3.2A By Dec. 31, 2015, implement the components of a sustainable performance management system.
- Objective 2.3.2B By Dec. 31, 2014, implement customer satisfaction and complaint processes.

STRATEGIC ISSUE AREA: FINANCIAL AND BUSINESS EXCELLENCE

STRATEGY 2.3.3 **DEVELOP, IMPLEMENT AND SUSTAIN INTEGRATED QUALITY IMPROVEMENT PROCESSES THROUGHOUT ORGANIZATIONAL PRACTICE, PROGRAMS, PROCESSES AND INTERVENTIONS.**

Objective 2.3.3A By June 30, 2013, and annually, 95% of activities identified in the Agency Quality Improvement Plan are complete based on established schedule.

GOAL 2.4 **OPTIMIZE COMMUNICATIONS.**

STRATEGY 2.4.1 **DEVELOP, IMPLEMENT AND IMPROVE INTERNAL AND EXTERNAL COMMUNICATION STRATEGIES AND PLANS.**

Objective 2.4.1A By June 30, 2013, deploy DOH rebranding to support unified messaging.

Objective 2.4.1B By Dec. 31, 2015, complete 95% of objectives in the DOH Strategic Communications Plan.

Objective 2.4.1C By Dec. 31, 2015, evaluate internal and external communications tools and resources.
See also STRATEGY 2.1.4: Use public health information technology and systems to efficiently improve business practices, and OBJECTIVES 2.1.4A-2.1.4E.

STRATEGIC ISSUE AREA: SERVICE TO CUSTOMER AND COMMUNITY

GOALS, STRATEGIES AND OBJECTIVES

GOAL 3.1 PROMOTE AN INTEGRATED PUBLIC HEALTH SYSTEM.

STRATEGY 3.1.1 IMPLEMENT AND LINK HEALTH IMPROVEMENT PLANNING AT STATE AND LOCAL LEVELS.

- Objective 3.1.1A By March 31, 2013, all CHDs will have produced a current (within the past 5 years) community health improvement plan.
- Objective 3.1.1B By March 31, 2013, all state and local health improvement plans will be aligned.
- Objective 3.1.1C By Jan. 31, 2013, and regularly thereafter, convene to assess SHIP progress with partners.

STRATEGY 3.1.2 INTEGRATE PLANNING AND ASSESSMENT PROCESSES TO MAXIMIZE PARTNERSHIPS AND COMMUNITY EXPERTISE IN ACCOMPLISHING GOALS.

- Objective 3.1.2A By Dec. 31, 2014, increase public health presence in the local planning process by ensuring all CHDs will attend a minimum of one county planning board, planning review committee, or regional planning meeting.
- Objective 3.1.2B By July 31, 2013, the DOH central office will establish a mechanism for sharing data and information from the local county health departments about community assessment work across organizations.

STRATEGY 3.1.3 SUPPORT LOCAL EFFORTS TO REVITALIZE COMMUNITIES.

- Objective 3.1.3A By Oct. 31, 2013, DOH will forge partnerships with Housing and Urban Development and other local, regional and federal funding agencies to develop a model program for improving housing conditions for vulnerable populations.

GOAL 3.2 ASSURE ACCESS TO HEALTH CARE.

STRATEGY 3.2.1 INCREASE ACCESS TO CARE FOR UNDERSERVED POPULATIONS.

- Objective 3.2.1A By Jan. 1, 2013, and annually, conduct a statewide safety net primary health care provider assessment.
- Objective 3.2.1B By July 1, 2013, each CHD in conjunction with local coalitions will develop a written plan to address the county's safety net primary health care needs. The plan should address primary care and oral health care provider roles in the community based on the assessment completed in objective 3.1.1A and will be updated annually.

STRATEGY 3.2.2 PROVIDE EQUAL ACCESS TO CULTURALLY AND LINGUISTICALLY COMPETENT CARE.

- Objective 3.2.2A By June 30, 2014, implement a Culturally and Linguistically Appropriate Services (CLAS) self-assessment tool.

STRATEGIC ISSUE AREA: SERVICE TO CUSTOMER AND COMMUNITY

GOAL 3.3 **EXPEDITIOUSLY LICENSE ALL HEALTHCARE PROFESSIONALS WHO MEET STATUTORILY MANDATED STANDARDS OF COMPETENCY.**

STRATEGY 3.3.1 **PROVIDE AN EFFICIENT LICENSURE PROCESS THAT MEETS STATUTORY REQUIREMENTS.**

Objective 3.3.1A By June 30, 2014, reduce the time to issue a license from receipt of an application from 69 days (2011) to 61.4 days.

Objective 3.3.1B By June 30, 2014, reduce the time to renew a license from 3.6 days (2011) to 1 day.

STRATEGIC ISSUE AREA: WORKFORCE DEVELOPMENT

GOALS, STRATEGIES AND OBJECTIVES

GOAL 4.1 ATTRACT, RECRUIT, AND RETAIN A COMPETENT AND CREDENTIALLED WORKFORCE.

STRATEGY 4.1.1 IMPLEMENT A COMPETENCY-BASED FRAMEWORK FOR RECRUITMENT AND TRAINING.

Objective 4.1.1A By Dec. 31, 2015, 95% of position descriptions will include competencies aligned to DOH core competencies framework.

Objective 4.1.1B By Dec. 31, 2015, 80% of employees will have documented Employee Development Plans that identify competency-based training.

STRATEGY 4.1.2 PROVIDE TRAININGS AND RESOURCES THAT SUPPORT AND DEVELOP CURRENT PUBLIC HEALTH EMPLOYEES.

Objective 4.1.2A By Dec. 31, 2015, deliver and evaluate competency-based certificate programs for public health employees.

Objective 4.1.2B By Dec. 31, 2015, evaluate effectiveness of lifelong learning opportunities in developing core competencies.

GOAL 4.2 ENSURE PARTNERSHIPS, SYSTEMS AND PROCESSES TO SUPPORT THE FUTURE WORKFORCE.

STRATEGY 4.2.1 DEVELOP, SUSTAIN AND IMPROVE AN AGENCY WORKFORCE DEVELOPMENT PLAN TO ENSURE CONTINUITY OF COMPETENT AND CREDENTIALLED WORKFORCE.

Objective 4.2.1A By June 30 of each year, 95% of activities identified in Agency Workforce Development Plan are complete based on established schedule.

APPENDIX A:

TRENDS, EVENTS AND FACTORS THAT IMPACT THE FLORIDA DEPARTMENT OF HEALTH

PUBLIC HEALTH SYSTEM ASSESSMENT FINDINGS

In 2011, the Florida DOH led a coordinated, statewide effort to assess the capacities of state and local public health systems. The goals of the assessment were several-fold: to create stronger systems through collaboration; to identify strengths, challenges and system-wide solutions; to foster quality improvement by using national benchmarks; to more fully inform community health improvement planning efforts; to prepare agencies for national voluntary public health agency accreditation; and, ultimately, to positively impact health outcomes of Floridians. State and local instruments from the National Public Health Performance Standards Program (NPHPSP) were used to measure the state's capacity to deliver the ten Essential Public Health Services (EPHS). This document focuses on the results of the state public health system assessment.

BACKGROUND. The NPHPSP seeks to ensure that strong, effective public health systems are in place to deliver EPHS. Developed as a collaborative effort of seven national public health organizations led by the Centers for Disease Control and Prevention (CDC), the NPHPSP provides instruments to assess state, local and governance capacities. There are four key concepts that frame the national standards: their design around the ten EPHS, a focus on public health systems, a structure that describes optimal standards of performance, and applicability to quality improvement processes. A public health system is defined as “all public, private and voluntary entities that contribute to public health activities within a given area.” Depicted as a network of entities, this construct recognizes the contributions and roles of partners in the health and well being of communities and the state.

The EPHS are the following:

- EPHS 1:** Monitor Health Status to Identify Health Problems
- EPHS 2:** Diagnose and Investigate Health Problems and Health Hazards
- EPHS 3:** Inform, Educate, and Empower People about Health Issues
- EPHS 4:** Mobilize Partnerships to Identify and Solve Health Problems
- EPHS 5:** Develop Policies and Plans that Support Individual and Statewide Health Efforts
- EPHS 6:** Enforce Laws and Regulations that Protect Health and Ensure Safety
- EPHS 7:** Link People to Needed Personal Health Services and Assure the Provision of Health Care when Otherwise Unavailable
- EPHS 8:** Assure a Competent Public and Personal Health Care Workforce
- EPHS 9:** Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-based Health Services
- EPHS 10:** Research for New Insights and Innovative Solutions to Health Problems

ASSESSMENT METHOD. On October 25, 26 and 27, 2011, diverse groups of public health professionals representing a wide spectrum of areas of expertise gathered for three half-day (8:30 am –12 noon) retreats to assess the performance and capacity of Florida’s public health system. A total of 53 representatives from the Florida DOH, county health departments and external partner agencies participated in the process. A core team of participants were present for the assessment of all ten Essential Public Health services (EPHS). Each day began with an overview of the NPHPSP instruments and assessment process. The workgroups were guided through the NPHPSP state instrument questions and discussion by a skilled facilitator, supported by a recorder who took notes of discussion points and proceedings. In instances when consensus was not apparent in the voting, the facilitator opened up the floor for further discussion and repeat voting. Each workgroup responded to the stem questions for their assigned essential services. Responses to sub-questions were determined by the core assessment team based on discussion notes and their participation in the sessions. Sub-questions were answered immediately following the discussion sessions. All responses were entered into a CDC-maintained database; reports of results were available within minutes of submission.

KEY FINDINGS. Assessment results point to areas of relative strength and challenges for the state public health system. The following groupings were used to indicate how well the model standard is being met: “Optimal Activity” (greater than 75%), “Significant Activity” (51–75%), “Moderate Activity” (26– 50%), “Minimal Activity” (1–25%) or “No Activity” (0%).

Results by EPHS Florida’s state public health system scored highest for capacity and performance in the following EPHS:

EPHS 2: Diagnose and investigate health problems and health hazards (84%, optimal activity)

EPHS 1: Monitor health status to identify community health problems (82%, optimal activity)

EPHS 5: Develop policies and plans that support individual and statewide health efforts (63%, significant activity)

Lowest scores were recorded in the following areas:

EPHS 8: Assure a competent public health and personal health care workforce (39%, moderate activity)

EPHS 10: Research for new insights and innovative solutions to health problems (45%, moderate activity)

EPHS 7: Link people to needed personal health services and assure the provision of health care when otherwise unavailable (46%, moderate activity)

No EPHS received performance scores in the “no activity” (0%) category. However, stem question 7.1.3 on state public health system responsibility for monitoring and coordinating personal health care delivery in the state received a “no activity” or 0% rating.

CHALLENGES AND OPPORTUNITIES. The following challenges and opportunities emerged from the review of the state public health system assessment and the aggregated local public system assessments. These attributes, assets and areas for improvement can be considered:

1) when determining priorities, goals and strategies for the state health improvement plan; 2) for developing performance indicators for use in the performance management system; 3) in selecting priorities in the state strategic plan; 4) in preparing the state health department for national voluntary agency accreditation; and 5) by statewide programs in programmatic planning and quality improvement efforts.

CHALLENGES. Several major system wide challenges emerged from the assessment data and discussions by assessment participants.

- **ASSURING A COMPETENT WORKFORCE** [Essential Public Health Service 8 (EPHS 8)]: lowest performance score (39%, moderate activity) among the ten EPHS. Noted weaknesses include:
 - Lack of resources for training, continuing education, recruitment and retention
 - Lack of succession planning, career ladders and advancement/leadership opportunities
 - Inefficient, ineffective leveraging of partnerships among agencies and institutions of higher learning to enhance and improve current workforce capacity and support education of future public health professionals
 - Low capacity of local public health systems to assess workforce composition, size, skills, gaps and recruitment and retention activities.
 - Lack of leadership development resources and opportunities in aggregate of local public health systems.
- **LINKING PEOPLE TO NEEDED HEALTH SERVICES** (EPHS 7): tied for second lowest performance score (45%, moderate activity). Related findings include:
 - Needed services include dental, mental health, substance abuse, primary care; also noted were lack of medical home for many and attention to needs of those aging out of youth services into adult services
 - Challenges in meeting disparate needs of populations due to geography, age, language, race/ethnicity, income, co-morbidities
 - Varying capacities in linking people to services and assuring service provision evident in wide range of scores across some model standards pointing to pockets of high and low capacity in geographic distribution and by program/health topic area
 - In the aggregate, local public health systems perform in the assurance role at higher capacity (65%, significant activity); however, many local systems view this as unacceptably low performance as the assurance function should be at optimal levels

- **RESEARCH FOR NEW INSIGHTS AND INNOVATIVE SOLUTIONS TO HEALTH PROBLEMS** (EPHS 10): tied for second lowest performance score (45%, moderate activity). Other findings include:
 - Public health research agenda not established in a collaborative process, nor are research goals written and shared across the system
 - Research not a priority for many county health departments and community-based service provider organizations
 - In the aggregate, local public health systems rated capacity to initiate or participate in research as the second lowest capacity of their entire assessment (49%, moderate activity)
- **PUBLIC HEALTH CAPACITY AND RESOURCES** across all ten EPHS: in the aggregate rated as lowest area of capacity among the model standards (46%, moderate activity) Model standards represent major components, activities or practice areas. Each essential service contains the following model standards: 1) planning and implementation, 2) state-local relationships; 3) performance management and quality improvement; and 4) public health capacity and resources. Related findings include:
 - Lack commitment of sufficient resources including financial, human, leadership, technology
 - System fragmentation exists
 - Insufficient workforce (numbers of and expertise of) to serve state's population
 - Local public health systems overall report reduced financial and human resources
- **PERFORMANCE MANAGEMENT AND QUALITY IMPROVEMENT** (model standard): garnered the lowest capacity ratings of the entire assessment in two EPHS. Those EPHS and findings are
 - **EDUCATING, EMPOWERING AND INFORMING** about health issues (EPHS 3) (25%, minimal activity)
 - Limited or no review of effectiveness of health communications, health education and promotion interventions
 - Minimal system wide assurance of accurate and current content of health communications, health education and promotion interventions
 - Minimal activity to assess system wide effectiveness of efforts to reach targeted populations with culturally and linguistically appropriate health communications and resource materials
 - Limited activity to manage overall system performance in informing, educating and empowering people about health issues
 - **MOBILIZING PARTNERSHIPS** to solve health issues (EPHS 4) (25%, minimal activity)
 - Limited or no system-wide review of partnership development activities.
 - Minimal activity to determine effectiveness of partnership efforts.
 - Limited or no system-wide review of participation and commitment of policy leaders and system partners in mobilization efforts.
 - In the aggregate, local systems rated capacity to build, facilitate and sustain coalitions, partnerships and strategic alliances as the second lowest of ten EPHS (59%, significant activity).

OPPORTUNITIES. The state public health system is not without opportunities that could be seized upon to move closer towards enhancing system performance and ultimately, improving the health outcomes of Floridians. Potential opportunities include:

- Emerging technologies in health care
- Advocacy potential for upcoming 2012 legislative session
- Capitalizing on strong system performance on EPHS 1 and 2 (monitoring health status and diagnose and investigate health problems) and high capacity across EPHS related to emergency preparedness
- Active involvement in budget reduction negotiations and agency efficiency discussions

FORCES OF CHANGE ASSESSMENT FINDINGS

The Florida DOH led a coordinated, statewide Forces of Change Assessment in 2011. This assessment addresses the issues of what is occurring or might occur that affects the health of our state or the state public health system and what specific threats or opportunities are generated by these occurrences. The forces identified serve as the foundation for identifying strategic issues. This appendix presents the results of the Forces of Change Assessment.

BACKGROUND. A Forces of Change Assessment is one of four comprehensive assessments recommended by the National Association of County and City Health Officials (NACCHO) as communities or states develop a health improvement plan. Participants engage in brainstorming sessions aimed at identifying trends, factors, and events that influence the health and quality of life of the community and the effectiveness of the local public health system.

ASSESSMENT METHOD. The Advisory Committee convened and participated in a facilitated session on October 17, 2011 to discuss and identify the forces that affect the public health system as part of the SHIP planning process. The group was asked to focus on issues such as factors that impact the environment in which the public health system operates; trends; legislation; funding shifts; federal, state and local legislation; technological advances; changes in organization of health care services; shifts in economic and employment forces; changing family structures; gender roles; and more. A summary of the Forces of Change Assessment is provided in the tables that follow and details are included in the Forces of Change Discussion section.

KEY FINDINGS

Opportunities for Synergy and Partnership in the Planning Process. The SHIP is an opportunity to educate leaders and policy makers to create synergy and crosscutting solutions to shared problems. Non-profit and community hospitals should be included in the planning process because they are required to conduct their own needs assessment in order to maintain their IRS tax-exempt status. Local health committees are also trying to integrate other types of assessments (e.g., environmental) with the Mobilizing for Action through Planning and Partnerships (MAPP) process to create a more holistic approach. Environmental assessments and Protocol for Assessing Community Excellence in Environmental Health (PACE EH) projects present additional opportunities to make improvements in the environmental impact on health. Integrating PACE EH with MAPP-based health improvement planning is an opportunity for a more holistic approach and will bring more partners to the table.

ECONOMIC AND DEMOGRAPHIC FORCES OF CHANGE. Florida is facing a series of economic and demographic challenges to our current health care system. This includes an aging and increasingly obese population, an increasing number of people without health insurance, the diminished capacity of health care safety net providers, difficulties associated with controlling health care costs, major pending changes to Florida's Medicaid service delivery system, and a growing shortage of health care providers.

Florida currently has one of the oldest resident populations in the nation. Older persons have increased health care needs. At the same time, Florida is seeing the prevalence of obesity increase across all age groups along with the adverse health consequences that obesity entails.

Workers are losing health insurance as more businesses are finding health insurance coverage too expensive to provide to their employees. Florida has one of lowest rates of health insurance coverage in the nation. The high rate of uninsured persons places great stress on our health care system, particularly the safety net system. Economic downturns impact health care providers as well. During economic downturns, providers typically experience reduced support from local, state, and federal sources while seeing more patients and proportionally more uninsured patients. This results in the perverse situation where demand on the system increases at the same time capacity decreases.

The conversion of Florida Medicaid to essentially a completely managed care service delivery system in 2014 presents both opportunities and risks. Opportunities include the potential for better access to, and coordination of, health care services to Medicaid recipients along with a higher degree of cost control. Risks include the extent to which Medicaid managed care plans can attract and retain quality health care providers and by extension the ability of Medicaid recipients to access needed services.

Hospitals serve as an important component of the health care safety net. The loss of hospital capacity, particularly those that serve the indigent, greatly impacts Florida's health care safety net. Many hospitals in Florida are struggling to remain solvent. Hospital occupancy is dropping as insurance companies move more care to an outpatient basis. Decreasing inpatient occupancy often leads to corresponding decreases in emergency department staffing and capacity. Although inappropriate, emergency rooms are still an important component of Florida's primary care safety net.

The nature of health care and the presence of third-party payers tends to inhibit the application of market competition, in part because the cost of services is frequently not the driving consideration. Market solutions to health care system problems can be challenging to develop and implement. The practice of "creaming" by provider organizations—working to obtain and maintain a panel of relatively healthy patients while minimizing the number of sicker and more costly patients—is a phenomenon that must be addressed to maintain an equitable and effective system. Fraud and the overutilization of services are also significant factors in our health care system. Current mechanisms for addressing fraud and encouraging the efficient use of resources appear inadequate.

The distribution of health care practitioners, particularly among nurses and dentists, is very uneven across the state and results in much diminished access to needed care. Florida's population is aging and having greater needs while at the same time our health care provider workforce is aging and retiring. There is great unmet need in Florida in the area of dental services to adults. Insurance coverage for dental care is often very limited, and Medicaid only covers emergency services and dentures for adults.

SUMMARY: ECONOMIC AND DEMOGRAPHIC FORCES OF CHANGE

CHALLENGES

- An aging population
- An increasingly obese population
- Increasing numbers of uninsured persons
- Diminishing health care safety net capacity on the part of Federally Qualified Health Centers, county health departments, and hospitals
- Difficulty implementing cost controls in the health care area
- Transitioning to a completely managed care Medicaid system

OPPORTUNITIES

- Interest in workplace wellness and behavioral change strategies are growing
- The economy is improving, which should improve the health care fiscal picture
- Managed care systems, implemented well and funded adequately, offer the opportunity for better coordinated care and improved access to specialists
- Managed care systems, implemented well and funded adequately, are well-positioned to support true patient-centered medical homes
- Providers and insurers are showing more interest in controlling health care costs and trying innovative programs
- The implementation of Medicaid risk-based capitation rates will lessen the impact of manipulated patient selection
- Managed care tends to better control practitioner-related fraud and abuse and discourage the provision of unnecessary services

ACCESS TO CARE FORCES OF CHANGE. Access to care, particularly on behalf of low-income persons, is becoming increasingly problematic. As addressed in the Economic and Demographic forces of change section, many safety net providers are experiencing reductions in their infrastructure which results in corresponding reductions such as fewer appointment slots, service offerings, and hours of operation. The closing of hospital emergency rooms sometimes denies persons access to the only outpatient medical care they are able to obtain.

Dental health, especially for low-income children, is greatly underutilized. A high proportion of low-income children in Florida are covered by Medicaid. However, private provider participation in the Medicaid Dental Program is minimal. Safety net providers could find their participation in the Medicaid Dental Program challenged by the move to managed care depending on the reimbursement rates available.

Dental care for adults is particularly problematic. Private dental insurance, if available, often provides very limited coverage whereas Medicaid only covers dentures and emergency services for adults. A recent analysis of emergency room patient data shows large costs associated with dental problems—approximately \$73 million. Medical studies also show that poor dental health can have a significant negative impact on a person's overall health including poor birth outcomes and cardiovascular disease.

Substance and prescription drug abuse among adults has increased the number of children in foster care. Both foster parents and their children need health and dental care. Only 60% of children in foster care are current with the Early Periodic Screening, Diagnosis and Treatment (EPSDT) schedule. Primary care medical homes need to be found for foster children and their parents. There is also a need to address CMS clients who are transitioning out of the CMS system into an adult care system.

SUMMARY: ACCESS TO CARE FORCES OF CHANGE

CHALLENGES

- The capacity of traditional safety net providers is decreasing
- Lack of true medical homes for many low income persons, persons in DCF care, and persons aging out of the CMS system
- Poor access to dental care on the part of the low-income population, particularly the Medicaid population
- More health care shortage areas are emerging geographically
- Increasing prevalence of adult substance abuse impacts families, children and foster care needs
- Greater need for behavioral health services
- Educating persons to use a primary care medical home when available rather than emergency rooms for primary care and an understanding the importance of preventive as well as acute care

OPPORTUNITIES

- Diminishing resources have led to an increased emphasis on partnering among providers
- Telemedicine offers the opportunity to significantly expand access to care, particularly in rural areas
- Managed care can be a vehicle to improve access to care, if implemented and managed properly
- There is increased recognition of the importance of good dental health on overall health
- The expanded scope of practice for Registered Dental Hygienists offers an opportunity to increase the provision of preventive dental care, the most cost-effective form of dental care
- Increased willingness to revisit and modify regulatory requirements to streamline activities and reduce cost

HEALTH CARE PRACTITIONER WORKFORCE FORCES OF CHANGE. Florida is experiencing worrisome trends in the health care workforce. Florida's health care practitioner workforce is becoming increasingly older and retiring at a higher rate. Florida's medical schools have relatively few residency slots from which replacement providers are often obtained. The health care practitioners Florida does have tend to be located in the more desirable urban and suburban areas and much less so in rural areas. As such, not only is the overall availability of health care providers becoming of more concern but so is the distribution of providers.

SUMMARY: HEALTH CARE PRACTITIONER WORKFORCE FORCES OF CHANGE

CHALLENGES

- Florida's health care provider workforce is aging
- Florida has significant shortages of health care providers in rural areas
- Florida has relatively few medical school residency slots
- Florida has a substantial number of rural counties and medically underserved areas

OPPORTUNITIES

- Florida is an attractive market and Florida can compete nationally for health care providers
- DOH's Medical Quality Assurance unit has strong provider assessment capability
- DOH has physician, dental and nursing assessments already completed
- DOH has a strong workforce development office and houses Florida's Primary Care Office funded by the Health Resources and Services Administration (HRSA)
- There is interest at the policy level in increasing the number of medical school residency slots
- Support exists for Primary Care programs in the state (i.e. Florida State University)

POLICY AND PRACTICE MODEL FORCES OF CHANGE. Debates related to the Affordable Care Act, health care coverage, federal deficit reduction, state funding shortfalls, the solvency of Medicare, and the future configuration of Medicaid have focused much attention on health care access and financing issues. This attention creates fertile ground for policy discussion, policy change, and experimentation with innovative models of preventive and acute health care programs. These include new partnerships among health care providers, non-traditional health insurance options, opportunities related to the use of health care extenders, the establishment of patient-centered medical homes and accountable care organizations, and shifting health care financing from service-based to performance/health care outcome-based. The SHIP presents an opportunity to initiate discussion and change on these and other issues.

Regarding partnerships, Florida's public health preparedness effort is an excellent model of public-private cooperation. Funding made available post-9/11 facilitated conversations beyond just emergencies that enhanced the integration of services and systems among state, federal, local and private entities. Well-organized public-private partnerships benefit from the strengths and competencies of both systems. The Primary Care Access Network (P-CAN) in Orange County, Florida, is an example of effective cooperation among state, county, and private interests to expand health care access and implement a more effective and cost-efficient health care system.

The escalating costs of health insurance and growing numbers of uninsured have led to renewed interest in new methods of providing health care coverage. Both policymakers and health insurance companies are open to innovative options such as health savings accounts, cafeteria-style health insurance policies, modified risk pools, modified rates based on health behavior. These could be discussed and initially pursued on a pilot basis.

Model school-based student wellness and worksite wellness programs are emerging. System-wide school wellness programs have a great impact in counties where the school district is a major employer. Recognition of healthy school districts arose from an assessment created by health and education partners and based on CDC's coordinated school health model that builds infrastructure around core areas including staff wellness, health education, physical education, nutrition services, healthy school environment, family and community involvement, health services, counseling, psychology, and social services. Florida now has 18 recognized districts.

Consideration should be given to the more aggressive use of physician extenders and laypersons such as Community Health Workers to expand access to basic and preventive health care services. The enhancement of preventive efforts is universally recognized as desirable; however, financially supporting these efforts has been problematic. Physician extenders and qualified laypersons could lessen this barrier.

Burdensome regulations create a disincentive for collaborative efforts and effecting change. There is a need to thoroughly review regulations in relation to their intent, application, and impact on the health care system. Regulations that inhibit progress and yield little benefit should be revised or discarded.

SUMMARY: POLICY AND PRACTICE MODEL FORCES OF CHANGE

CHALLENGES

- Categorical funding, reporting, and administrative systems that reinforce isolation
- History of competition rather than cooperation among providers
- Misunderstanding of privacy and confidentiality laws that inhibit coordination
- Overly burdensome regulations
- Continued reductions in required physical education in schools
- Minimal participation in school-based physical education when available
- An increasingly sedentary lifestyle
- Current lack of strong health care cost and utilization controls

OPPORTUNITIES

- Willingness of policymakers and providers to consider new ideas
- Willingness to support pilot and demonstration projects
- Recognition of patient-centered medical home concept
- Recognition of the efficacy of preventive health services
- Use of the SHIP to educate the public and policy makers about what is important in public health
- Many good model practices exist that can be expanded

EXAMPLES:

- ◆ Public Health Preparedness
- ◆ Healthy School Districts
- ◆ Youth surveys (collaboration on questions and sharing results)
- ◆ Use of lay health care facilitators
- Propose changes in regulations to improve service delivery
- Increase coordination of local health planning.

EXAMPLES:

- ◆ Non-profit, community hospitals (have an IRS requirement for an assessment)
- ◆ Local health committees' assessments that integrate with the MAPP process
- ◆ Integrate environmental assessments with other community health improvement assessments.

COMMUNITY THEMES AND STRENGTHS ASSESSMENT FINDINGS

Community Themes and Strengths Assessment results present perspectives from a cross-section of the public health system that includes Florida citizens and residents, state and community public health partners, and local county health departments. Specifically, this assessment seeks to answer the following questions:

What is important to our state?

How is quality of life perceived in our state?

What assets do we have that can be used to improve Florida's health?

BACKGROUND. The Community Themes and Strengths Assessment is one of four assessments that serves as the framework for the State Health Improvement Plan (SHIP). This document summarizes findings from several facets of the statewide public health system.

ASSESSMENT METHOD. The Community Themes and Strengths Assessment Team identified the priorities, resources and quality of life issues by analyzing data from the Community Health Improvement Survey, county health department strategic plans and the Behavioral Risk Factor Surveillance Survey data.

- **COMMUNITY HEALTH IMPROVEMENT SURVEY** Since 2003, county health departments have responded to an annual survey on community health improvement activities. The survey ascertains the unique capacities, current and planned community health improvement activities, and training, technical assistance and resource needs. The Assessment Team reviewed survey results from 2003 through 2011, looking at trends in how county health departments answered the questions “What themes are being addressed by community-identified strategic issues?” and “What topics are being addressed by community-identified goals and objectives?” Because Florida’s county health departments use the community-driven strategic planning tool, Mobilizing for Action through Planning and Partnerships, the answers to these questions reflected the concerns of a wide spectrum of residents of each county.
- **COUNTY HEALTH DEPARTMENT STRATEGIC PLANS** The Assessment Team reviewed and analyzed county health department strategic plans to ascertain local health priorities, existing infrastructure and resource allocation. This analysis provided another source of data that confirmed findings from the community health improvement survey by showing that at the local level, access to health care and chronic diseases are leading priorities.

- **BEHAVIORAL RISK FACTOR SURVEILLANCE SURVEY** BRFSS is a survey of randomly selected respondents ages 18 and older throughout the state about their health behaviors and preventive health practices related to the leading causes of morbidity and mortality. Additionally, the BRFSS queries participants about their perceived quality of life and the correlates that impact health and well-being. These data provide insight into how residents of our state perceive their quality of life. The Assessment Team reviewed 2007 and 2010 data from key survey questions: “percent of adults with good to excellent overall health;” “percentage of adults who are limited in any way in any activities;” “percentage of adults who use special equipment because of a health problem;” “percentage of adults who are ‘very satisfied’ or ‘satisfied’ with their lives;” “percentage of adults who always or usually receive the social and emotional support they need;” “percentage of adults with good physical health;” “percentage of adults with good mental health.”
- **ASSETS AND COMMUNITY RESOURCES** The Florida DOH maintains its own snapshot that describes the priorities around which the agency and county health departments have chosen to organize their resources and efforts in support of the agency’s mission and vision. County health departments, in particular, function as the primary mechanisms of direct public health services. This document incorporates several areas of importance: health components, service populations, resources and organizing principles.

KEY FINDINGS

ACCESS TO CARE AND HEALTH BEHAVIORS. The recurring themes in local community health assessment and health improvement planning processes in Florida are access to health care and health behaviors.

- Nearly all 67 county-level community health assessment and health improvement planning processes identified access to health care as a strategic health priority area.
- Diabetes, obesity and overweight, tobacco use and teen pregnancy were specified as health issues affecting communities and in need of intervention.
- Dental issues emerged in 2010 as a priority community health improvement topic for more than half of the communities.
- Concern over the public health infrastructure and policies and laws has continued to grow in significance over the past several years.

QUALITY OF LIFE. As people are living longer, quality of life becomes increasingly important to Floridians. Quality of life refers to perceived physical and mental health that impacts overall health status.

- A large majority of Floridians report a good quality of life that includes both mental and physical health.
- About nine out of every ten adult Floridians report being satisfied with their lives.
- Four out of every five adult Floridians report that they usually receive the social and emotional support they need.
- A minority of adult Floridians report physical and emotional limitations.
- Nearly a quarter of adult Floridians are limited in some way in their activities.
- One out of every ten adult Floridians uses special equipment because of a health problem.

ASSETS AND COMMUNITY RESOURCES. Through identifying resources, community partners can analyze whether there are unrecognized assets or opportunities from which they can draw to enhance quality of life and to improve health outcomes.

- Locally, a network of partnerships exist between health care providers and ancillary care groups that augment the health care needs of the population in each county.
- DOH administers public health through 67 county health departments. They are the primary service providers in the areas of infectious disease control and prevention, family health services and environmental health services. Statewide functions such as the laboratories, Vital Statistics, a state pharmacy, and disaster preparedness and emergency operations assure efficient and coordinated approaches to monitoring diseases and responding to emerging needs at a population level.
- DOH provides specialized assistance to pregnant women, infants and children with special health care needs through its Children's Medical Services (CMS) Program. The statewide network of 22 local CMS clinics as well as private physicians' offices, regional medical centers and medical specialty care service centers includes a range of providers not usually available through individual health plans. CMS also coordinates care with community agencies such as schools and social service agencies.
- DOH's Health Care Practitioner and Access program improves access to health care and ensures practitioners meet licensing and practice requirements according to accepted standards of care. This program coordinates the placement of health care professionals in underserved areas through Area Health Education Centers, rural health networks and local health planning councils.
- Florida's public health statutes have been recently reviewed and are keeping pace with scientific developments and current constitutional, legal and ethical changes.

HEALTH STATUS ASSESSMENT FINDINGS

DOH led a coordinated, statewide effort to assess the health status of Floridians. The goal of the assessment was to identify the major causes of mortality and morbidity in the state as well as behaviors and health care access issues that exacerbate the identified conditions. This document presents the key findings of the Health Status Assessment.

BACKGROUND. Florida is a large and diverse state with nearly 19 million residents and approximately 80 million visitors each year. In 2010, 22% of the population identified as Hispanic, and adults ages 65 and older accounted for a larger proportion (17.7%) of Florida's population than in any other state. Life expectancy in Florida surpassed that of the US in 2000, and the gap continues to widen over time. In fact, Floridians' life expectancy is longer now than at any other point in history; a person born in Florida in 2010 can expect to live 79.8 years.^E As life expectancy extends, Florida's elderly population continues to grow. Florida's public health system successes include reductions in:

- Cardiovascular disease and cancer deaths
- Tobacco use
- Teen pregnancy rates
- Cases of vaccine-preventable diseases in young children
- Foodborne and communicable diseases

Nevertheless, the public health system continues to be challenged by the growth and diversity of Florida's population, the complexity of current public health problems, and lack of access to quality medical and preventive health services for many Florida residents.

ASSESSMENT METHOD. The Health Status Assessment Workgroup included staff from the Office of Health Statistics and Assessment, the state epidemiologist, and lead epidemiologists in communicable and chronic diseases, environmental health, and maternal and child health. The workgroup identified leading causes of mortality and morbidity and health-related behaviors using existing birth, death, surveillance, hospitalization and survey data. Key informants in the partner agencies were interviewed to broaden the scope of issues being considered and to gather data related to each issue. All leading causes of mortality and morbidity and the health-related behaviors underlying them were compiled and a facilitated consensus process was held through which the state epidemiologists selected issues that would be advanced to this summary and to the SHIP Steering Committee. Criteria used for selection included health issues that affect a large percentage of the population, show evidence of disparity, or have been identified by the CDC as Winnable Battles (known effective strategies for improving outcomes within five years).

KEY FINDINGS

The key health status issues identified by the Health Status Assessment Workgroup were:

- Chronic diseases
- Tobacco
- Overweight, obesity and physical inactivity
- Unintentional injury and prescription drug abuse
- Infant mortality and prematurity
- Unintended and teen pregnancy
- Breastfeeding
- Child abuse, neglect and other adverse childhood events
- Depression and behavioral health
- HIV and AIDS
- Influenza
- Access to care
- Emerging health issues

Health status issues are not mutually exclusive. For example, injury and chronic disease outcomes are associated with access to care while infant mortality and prematurity are associated with unintended and teen pregnancy. A short discussion of each health status issue follows. Throughout the discussion, Florida's national ranking is provided on a scale of 1 to 51 (which includes 50 states and Washington, DC). A ranking of 1 is considered best, while a ranking of 51 is considered worst. Age-adjusted rates per 100,000 population are also referenced in this discussion. An age-adjusted rate is a measure that allows one population to be compared to another without concern for the age structure of that population. This is very important when comparing Florida to the US, since Florida has a larger proportion of the elderly.

CHRONIC DISEASES

Several chronic diseases were considered priorities by the state epidemiologists: high blood pressure; heart disease and stroke; cervical, colorectal and breast cancers (cancers for which screening is readily available leading to early diagnosis); diabetes and asthma.

HIGH BLOOD PRESSURE (HYPERTENSION). According to the 2010 BRFSS, 34.3% of Floridians have been diagnosed with hypertension. Prevalence differs across subpopulations: black adults at 41.7%, white adults at 35.4%, Hispanic adults at 24.8%, and those over age 65 at 61.7%.^c

HEART DISEASE. Heart disease was the leading cause of death in Florida in 2010.^E Among heart disease deaths, heart attack represents a significant proportion of those deaths at about 19% since 2007.^E While deaths from heart attack have declined in Florida from 189 per 100,000 persons in 1970 to 27.7 per 100,000 persons in 2010 (age-adjusted rates), blacks and Hispanics are still 1.3 times more likely than whites to have died from a heart attack.

STROKE. In 2007, Florida ranked fourth best in the nation for age-adjusted death rates due to strokes.^D Despite the fact that the age-adjusted death rate for stroke has declined over the past 40 years, Florida's rate for blacks continues to be about twice the rate of whites and Hispanics.^E Blacks are almost twice as likely to die from stroke as whites and almost twice as likely to be hospitalized.^{E,P}

CANCER (MALIGNANT NEOPLASM). Cancer was the second leading cause of death in Florida in 2010, accounting for 28.4% of all deaths.^E While the age-adjusted death rate from cancer has steadily decreased since 1990 from 208.0 to 159.2 per 100,000 population in 2010, it was still the leading cause of death for individuals aged 45–84, accounting for 35.6% of the total deaths in this age group. Together, cervical, colorectal and breast cancers account for 16.6% of all of Florida's cancer deaths. Because regular screenings have been shown to be an effective means of reducing the associated mortality, cervical, colorectal and breast cancers were identified as key health status issues. The distribution of all three of these types of cancers is greater among non-Hispanic blacks than whites. The age-adjusted death rate for cervical cancer for blacks is 1.7 times that of whites. Although Hispanics and blacks have nearly equal proportions of deaths from colorectal cancers, the black age-adjusted death rate for colorectal cancer is 1.4 times that of whites. In 2007, Florida ranked 13th among the states in breast cancer deaths, 22rd in cervical cancer deaths and 12th in colorectal cancer deaths.^B

DIABETES. Diabetes prevalence is at an all time high. Diabetes mellitus was the sixth leading cause of death in Florida in 2010 with a rate of 26.6 per 100,000 population,^E and in 2007, Florida ranked 15th nationally in death rates from diabetes.^D In 2010, compared with whites, blacks had higher rates of diabetes deaths (39.0 versus 17.1 age-adjusted death rate per 100,000 population),^E hospitalizations (4,264.2 versus 1,867.8 age-adjusted hospitalization rate per 100,000 population),^P and amputation due to diabetes (68 versus 19.6 per 100,000 population).^P Each year since 2004, the percentage of Floridians diagnosed with diabetes has continued to exceed the US average for black, white and Hispanic populations.^C This is a winnable battle, with established clinical management guidelines.

ASTHMA. Asthma is a chronic respiratory disease, which causes wheezing, breathlessness, chest tightness, and coughing, and can greatly limit an individual's quality of life and level of productivity. According to the CDC's 2008 estimates, about 10.2% of adults in Florida have ever had asthma, and 6.6% of adults currently live with asthma. That number is increasing each year, mirroring national statistics. The number of people diagnosed with asthma grew from 7.3% in 2001 to 8.4% in 2010, when 25.7 million persons had asthma.^Q Florida statistics show a steady increase in hospitalizations due to asthma, from just over 200 per 100,000 population in 1990 to over 700 per 100,000 in 2010.^P

It's important to highlight disparities and the need to target effected populations with interventions and care. For the period 2007–2009, asthma visit rates (per 100 persons with asthma) in primary care settings for black persons were similar to those for white persons, but rates for asthma emergency department visits, hospitalizations, and deaths were higher. The black rate of asthma hospitalizations in 2010, at 1,205.2 per 100,000 persons was 1.9 times that of the white rate at 644.7 per 100,000 population.^P

TOBACCO

In the US, more deaths are caused each year by tobacco use than all deaths from HIV, illegal drug use, alcohol use, motor vehicle injuries, suicides and murders combined. Smoking increases the risk of coronary heart disease and stroke by a factor of two to four and of dying from chronic obstructive lung diseases by a factor of 12.⁵ In 2010, Florida ranked 24th nationally in percentage of smokers.^C Tobacco use in Florida has declined over time, but greater progress is still possible through cessation, reducing second-hand smoke exposure and youth tobacco prevention activities.

OVERWEIGHT, OBESITY AND PHYSICAL INACTIVITY

Over the past decade, obesity has become recognized as a national health threat and a major public health challenge. Obese adults are at increased risk for serious health conditions including coronary heart disease, hypertension, stroke, type 2 diabetes, and certain types of cancer. Adult obesity is also associated with reduced quality of life, social stigmatization, and discrimination.^T The 2012 Institute of Medicine report *American's Obesity Crises* cites \$190.2 billion as the estimated annual cost of obesity-related illness with 21% of annual medical spending on obesity-related illness, and 27% of the increases in U.S. medical costs associated with obesity-related diseases.^T Consequently, the US Surgeon General has called for strong public health action to prevent and decrease overweight and obesity. In 2010, Florida ranked 45th nationally in its proportion of population that was overweight and 24th in the proportion who were obese.^C In 2010, 25.2% of Florida's white population, 42.7% of its black population, and 29.2% of its Hispanic population were obese.^C Regular physical activity not only helps people to avoid being overweight, but reduces the risk for other adverse health conditions such as coronary heart disease, stroke, high blood pressure, high cholesterol or triglycerides, type 2 diabetes and more.^U Florida ranks 34th among states in physical activity, with the black and Hispanic population less likely to engage in regular, moderate physical activity than whites.^C Eating a healthy diet is another recommended strategy for maintaining healthy weight. Yet, in 2009, only one-quarter of adult Floridians met the dietary goal of five fruits and vegetables daily. Since 2000, Hispanics have had the lowest rate of adequate fruit and vegetable consumption.^C

UNINTENTIONAL INJURY

In 2007, Florida ranked 32nd among all states in unintentional injury-related deaths.^F In 2010, within Florida, unintentional injuries were the 4th leading cause of death among all age groups and the leading cause among those younger than 45 years old.^E Florida's epidemiologists identified the following unintentional injuries as significant health issues: prescription drug abuse and motor vehicle injuries including bicycle and pedestrian injuries, falls among the elderly population and drowning among children.

PRESCRIPTION DRUG ABUSE. Florida has experienced a substantial rise in unintentional poisoning deaths over the past two decades—the overwhelming majority of which can be attributed to the abuse of prescription and illegal drugs. The number of unintentional poisonings, officially classified as “deaths from poisoning and noxious substance exposure”, rose from 954 deaths in 2000 to 2,582 in 2010. Consequently, unintentional poisonings have now surpassed motor vehicle accidents as the leading cause of unintentional injury death among Floridians.^E

MOTOR VEHICLE CRASH FATALITIES. In Florida, fatalities from motor vehicle crashes have dropped each year—from 3,491 in 2005 to 2,449 in 2010.^E The State Mileage Death Rate (the number of deaths per 100 million miles traveled) decreased to 1.25 deaths per 100 million vehicle miles traveled in 2010—the lowest since the rate has been calculated.^V Although motor-vehicle crash fatalities are generally declining in Florida, the rate among those aged 16–24 (20.0 per 100,000 population) is substantially higher than the overall rate in both Florida (13 per 100,000 population) and in the US (11.0 per 100,000 population).^F In 2007, Florida ranked 35th nationally in the rate of motor vehicle accident deaths.^F

In addition to motor vehicle deaths, bicycle and pedestrian safety was a concern. In 2010, the Department of Highway Safety and Motor Vehicles reported 76 bicyclists killed, 4,600 bicyclists injured and 4,925 bicycle crashes as well as 499 pedestrians killed, 7,290 pedestrians injured and 7,894 pedestrians involved in crashes in Florida.^V

FALLS. Among the elderly, injuries from falls are a major cause of disability and death. Florida's 2008–10 death rate due to unintentional falls among those ages 65 and over, at 51.6 per 100,000, was significantly greater than the total state rate of 7.1 per 100,000.^E The large proportion of older adults in Florida makes this issue a growing concern.

CHILDHOOD DROWNING. The overall age-adjusted death rate from drowning in Florida decreased from 2.5 per 100,000 in 1991 to 1.9 per 100,000 in 2010. Those aged 0–4 consistently have the highest rates of drowning (9.3 in 1989–91 to 6.0 in 2008–2010). This age group accounted for the largest proportion of drowning deaths in the state in 2010 at 18.45%.^E

INFANT MORTALITY AND PREMATURITY

Infant mortality is often used as a measure of overall population health. In 2009, Florida's infant mortality rate ranked 29th among the states,^D and in 2010, black babies born in Florida were 2.5 times as likely to experience an infant death as white babies.^E Preterm birth is a major contributor to infant mortality. In 2009, Florida was ranked 42nd nationally in its rate of preterm birth,^D with black mothers experiencing preterm birth 1.5 times more often than white mothers.^E

UNINTENDED AND TEEN PREGNANCY

A 2011 study reported that 49% of pregnancies in the US in 2006 were unintended and among women 19 years and younger, four out of five pregnancies were unintended.^W Unintended pregnancy is associated with an increased risk of morbidity and mortality for women and with adverse outcomes for infants related to late-onset prenatal care.^W Women of all ages may have unintended pregnancies, but some groups, such as teens, are at higher risk.^W Florida ranks 20th in unintended pregnancy^H and 29th in teen pregnancy.^I In 2009, the percentage of teenage mothers who had another birth within their teenage years was 18.9%, ranking Florida 41st in the US.^I

BREASTFEEDING

Breastfeeding is one of the best ways to start life. Breastfeeding provides nutrients and antibodies, is easier for babies to digest, and is associated with reduced risks of respiratory infections, asthma, obesity, type 2 diabetes and sudden infant death syndrome.¹ In Florida, in 2010, 69.6% of black mothers initiated breastfeeding their infants before being discharged from the hospital as compared to 83% of white mothers and 87.6% of Hispanic mothers.^E Mothers born in the US were less likely to initiate breastfeeding compared with foreign-born mothers.

CHILD ABUSE, NEGLECT AND OTHER ADVERSE CHILDHOOD EVENTS

Nationally, in 2010, child protective organizations received over 3.3 million reports of alleged maltreatment of approximately 5.9 million children. Victims in the age group of birth to 1 year had the highest rate of victimization at 20.6 per 1,000 children. The overall rate of child fatalities was 2.07 deaths per 100,000 children. More than 30 percent (32.6%) of child fatalities were attributed exclusively to neglect, and more than 40 percent (40.8%) of child fatalities were caused by multiple maltreatment types.^Y Child abuse and neglect can result in death, disability, poor school performance, teen pregnancy, and mental and emotional disorders. Child abuse is a risk factor for violent behavior in adolescents and adult criminality. In adulthood, victims of childhood abuse and neglect are more likely to experience drug use, hypertension, depression and a shortened lifespan.^Z Primary, secondary and tertiary prevention programs can improve opportunities for children to be raised in healthy, safe, stable and nurturing family environments, yet Florida's rate of child abuse to those ages 5–11 has increased from 6.8 per 1,000 children in 2003 to 11.3 in 2010.

DEPRESSION AND BEHAVIORAL HEALTH

An estimated 12 million American adults are living with major depression.^X Depression can interfere with normal functioning and frequently causes problems with work, social and family adjustment and can be costly and debilitating to sufferers. It can adversely affect the course and outcome of common chronic conditions, such as arthritis, asthma, cardiovascular disease, cancer, diabetes, and obesity. Depression also can result in increased work absenteeism, short-term disability, and reduced productivity.^X As a marker for depression, Florida's rate of attempted suicide (102.9 per 100,000) exceeded the national rate of 87.9 in 2009.^F Suicide was the ninth leading cause of death for Floridians in 2010.^E

HIV AND AIDS

HIV disease includes all people with evidence of HIV infection, regardless of immune status or symptoms. AIDS cases are a subset of those with HIV disease. Since the AIDS epidemic began in 1981, over 1.7 million Americans have been infected with HIV and over 600,000 have died of AIDS-related causes. An estimated 21% of people living with HIV are undiagnosed, and every 9.5 minutes, a new case is found.^{LM} In Florida, the rate of new HIV disease cases has decreased from a peak of 69.5 per 100,000 residents in 1998 to 26.5 per 100,000 residents in 2010. The overall decreases in HIV disease and AIDS diagnoses have been observed across all racial and ethnic groups; however, blacks are still 9.6 times more likely than whites to be diagnosed with HIV.^K In 2010, the age-adjusted HIV/AIDS death rate for blacks was 22.2 per 100,000 population as compared to 3.0 per 100,000 for Hispanics and 2.5 per 100,000 for whites.^E In 2009, Florida ranked 49th in its age-adjusted death rate for HIV and AIDS^D, 51st in HIV cases^K and 49th in AIDS cases.^K

INFLUENZA

Influenza affects approximately five to twenty percent of US residents annually, resulting in loss of work, productivity and school attendance. The effects of influenza are more extreme among the young and the older populations.⁴ Compared to residents in other states, Floridians are less likely to be vaccinated for influenza. In particular, the overall prevalence of flu immunization among Floridians ages 65 years and older has been slightly lower than the national prevalence for the past decade.

ACCESS TO CARE

Access to care includes availability of health insurance, providers and health care facilities. Health insurance helps people engage in preventative care and seek treatment before their illness becomes chronic. Based on three-year estimates (2008–2010), Florida ranked 49th in the country for the percentage of its population who were uninsured.⁸ According to the US Census, 21% of Florida's population does not have health insurance.⁶ Of these, 25% are currently employed but still lack health insurance, primarily because many work part-time and are ineligible for employer benefits. The numbers of children and adults without health insurance are increasing, and blacks and Hispanics are more likely to be uninsured than whites. While 19.1% of the white population has no health insurance, 25.7% of blacks and 34.3% of Hispanics are uninsured. In Florida, those ages 25–34 constitute the highest percentage of people without insurance coverage (37%), followed by those ages 35–44 (31%). Almost 13% of children (ages 0–17) are uninsured. In 2007, 15.1% of adults in Florida reported they could not see a doctor at least once in the past year due to cost, which rose to 17.3% in 2010.

DENTAL CARE AND ORAL HEALTH. Dental care and oral health are related to serious medical conditions such as heart disease, premature birth and low birth weight, and infections of the blood and bones.² Access to dental care is as important as health insurance. In 2010, only 66% of the general population had visited a dentist within the past year.^c In 2007, 19.2% of adult Floridians could not see a dentist because of cost.^c Over one-third of dentists are over age 55, and the number graduating is not enough to replace the number retiring.

HEALTH CARE PROVIDERS. A shortage of as many as 150,000 doctors is predicted for the US in the next 15 years, according to the Association of American Medical Colleges. Too few providers will limit access to health care and create longer wait times for appointments. Additionally, financial rewards for specialty care physicians far outweigh those of primary care physicians; yet, it is primary care physicians who are most needed for serving the general needs of a population. Given current graduation and training rates, health care providers will continue to be in great demand in Florida. Currently, Florida has 1,329 health care shortage areas for primary care, 1,146 shortage areas for dental care and 276 shortage areas for mental health. These areas, defined by the US Department of Health and Human Services, are designated based on specific criteria about the geography, population and facilities in an area.³ Health facilities also contribute to the ability to care for a population. Since 2008, very little change has occurred in the number of hospital beds, specialty beds, nursing home beds, adult psychiatric beds, or substance abuse beds per 100,000 residents despite growing needs.^p

EMERGING ISSUES

Florida must also be prepared to deal with the continual threat of natural disasters, health emergencies, health misinformation, tropical diseases and epidemics. The state epidemiologists identified the following emerging issues that Florida will have to monitor carefully over the next decade:

- Our tropical climate provides an environment hospitable to many organisms that could not prosper in colder climates, and the continued threat of new or more virulent strains of infectious diseases such as malaria, dengue fever, cholera, tuberculosis and hepatitis B, related to the influx of migrants, immigrants and refugees is of concern.
- Decline or non-acceptance of proven childhood immunizations and prevention strategies due to public misperceptions (for example, basic series and HPV immunizations, water fluoridation) continues to be a challenge.
- Florida has many older homes with lead-based paint as well as an immigrant population with lead poisoning or who are at risk due to occupational hazards. This is a winnable battle.

HEALTH STATUS ASSESSMENT FINDINGS

SELECTED INDICATORS

	Year	Healthy People 2020 Goals	State Rank	US Rate	FL Rate	White	Black	Hispanic
CHRONIC DISEASES								
Hypertension Prevalence ^C	2009	26.9%	42	28.7%	32.1	33.6	38.2	25.2
Heart Disease Age-Adjusted Death Rate ^{5E}	2008		10	186.5	154.6	156.3	196.0	155.2
Stroke Age-Adjusted Death Rate ^{DE}	2007	33.8	4	42.2	30.3	30.7	57.0	28.5
Cervical Cancer Age-Adjusted Death Rate ^{ABE}	2007	2.2	22	2.4	2.5	2.2	3.7	2.1
Colorectal Cancer Age-Adjusted Death Rate ^{ABE}	2007	14.5	12	16.7	14.2	14.4	18.6	13.6
Breast Cancer Age-Adjusted Death Rate ^{ABE}	2007	20.6	13	22.8	20.8	19.0	27.5	13.5
Diabetes Age-Adjusted Death Rate ^{DE}	2007		15	22.5	19.1	18.1	43.5	20.6
People Who Have Been Told by a Doctor They Have Diabetes ^C	2010		43	8.7%	10.4%	10.1%	13.1%	9.6%
Asthma Hospitalizations (per 100,000) ^N	2009			672.8	769.7			
TOBACCO								
Adults Who Currently Smoke ^C	2010	12%	24	17.3%	17.1%	18.4%	13.7%	13.8%
OVERWEIGHT, OBESITY AND PHYSICAL INACTIVITY								
Adults Who are Overweight (BMI >25) ^C	2010		45	36.2%	37.8%	37.9%	36.3%	37.3%
Adults Who are Obese (BMI >=30) ^C	2010	30.6%	24	27.6%	27.2%	25.2%	42.7%	29.2%
Adults Who Engaged in Any Physical Activity During the Past Month ^C	2009		34	76.2%	75.3%	78.2%	71.6%	68.3%
Adults Who Eat Five Servings of Fruits and Vegetables per Day ^C	2009		20	23.4%	24.4%	25.4%	24.5%	21.4%
UNINTENTIONAL INJURY								
Unintentional Injury Age-Adjusted Death Rate ^{EF}	2007	36	32	40	42.6	48.3	33.2	34.3
Motor Vehicle Accident Age-Adjusted Death Rate ^{E5}	2007	12.4	35	14.4	13.6	18.3	14.7	17.8
Fall Death Rate, Ages 65+ ^{DE}	2007	45.3		45.3	44.7	46.9	19.4	25.9
Drowning Death Rate, ages 0-4 ^{FE}	2009			2.32	6.2	5.7	5.8	4.4

STATE RANKINGS: 1=most favorable; 51=least favorable among 50 states and Washington, D.C

‡ Ranking is among the 25 Prenatal Risk Assessment and Monitoring System (PRAMS) participating states

HEALTH STATUS ASSESSMENT FINDINGS

SELECTED INDICATORS

	Year	Healthy People 2020 Goals	State Rank	US Rate	FL Rate	White	Black	Hispanic
INFANT MORTALITY AND PREMATURITY								
Infant Mortality Rate (per 1,000 live births) ^{ED}	2009	6	29	6.7	6.9	4.9	13.2	5.5
Preterm Birth (less than 37 weeks gestation) ^{E9}	2009		42	12.2	13.5	12.5	18.6	13.7
UNINTENDED AND TEEN PREGNANCY								
Unintended Pregnancies ^H	2008	44%		49%	47.4%	45.5%	65.5%	41.8%
Birthrate to Teens Ages 15–19 ^{EI}	2008		29	42	37.4	34.7	61.3	48.7
Repeat Births to Teens Ages 15–19 ^{EI}	2009		41		18.9%	28.3%	38.5%	30.6%
BREASTFEEDING								
Mothers Who Initiate Breastfeeding ^E	2010				80%	83%	69.6%	87.6%
DEPRESSION AND BEHAVIORAL HEALTH								
Attempted Suicide (per 100,000) ^F	2009			87.9	102.9			
Adolescent Suicide Attempts, 9–12th Grade ^J	2009		8	6.30%	6.50%	5.20%	7.30%	7.90%
HIV AND AIDS								
HIV and AIDS Age-Adjusted Death Rate (per 100,000) ^P	2009	3.3	49	3	6.5	3	25.9	4
HIV Incidence (per 100,000) ^{KLM}	2009		51	17.4	29.8			
AIDS Incidence (per 100,000) ^M	2009	13	49	11.2	23.7			
INFLUENZA								
Pneumonia and Influenza Age-Adjusted Death Rate ^{DE}	2007		1	16.2	8.5	8.1	11.5	7.0
Adults 65 and Over Who Received a Flu Shot in the Past Year ^C	2010	90.0%	38	67.5%	65.6%	70.0%	41.6%	44.1%
ACCESS TO CARE								
Adults Without Health Insurance ⁸	2010	0%	49	17.8%	21.5%	17.1%	26.7%	32.8%
Adults Who Visited a Dentist within the Past Year ^C	2010		39	69.7%	66.4%	69.5%	56.9%	62.0%
Total Physicians (per 10,000) ^O	2008		26	25.7	24.2			
Total Dentists (per 10,000) ^O	2007		30	6.0	5.3			
Total Hospital Beds (per 1,000 population) ⁷	2010		22	2.6	2.8			

STATE RANKINGS: 1=most favorable; 51=least favorable among 50 states and Washington, D.C

‡ Ranking is among the 25 Prenatal Risk Assessment and Monitoring System (PRAMS) participating states

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APPENDIX B:

STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS			
STRENGTHS		WEAKNESSES (OFIS)	
Internal to DOH (from review of NPHPS state system assessment, health status assessment, DOH Profile)	DOH has a strong workforce development office	Resources for training, continuing education, recruitment and retention. It is difficult to recruit & retain staff due to low salary structure and a low opinion of public employees.	Internal to DOH (from review of NPHPS state system assessment, health status assessment, DOH Profile)
	Our workforce is diverse and culturally competent	Succession planning, career ladders, and advancement and leadership opportunities	
	Opportunities related to workforce development have been identified in an agency Workforce Development Plan.	Need to better leverage partnerships among agencies and institutions of higher learning to enhance and improve current workforce capacity and support education of future public health professionals	
	DOH's Medical Quality Assurance unit has strong provider assessment capability	Improve resources and opportunities for leadership development	
	DOH has physician, dental and nursing assessments already completed	Increase opportunity to meet the disparate needs of populations due to geography, age, language, race, ethnicity, income, and co-morbidities. In particular, needed services include dental, mental health, substance abuse, and primary care.	
	Locally, networks of partnerships exist between health care providers and ancillary care groups that augment the health care needs of the population in each county	Assess pockets of high and low capacity in geographic distribution and by program and health topic area	
	DOH houses Florida's HRSA funded Primary Care Office	Numbers of health care providers in rural areas	
	DOH provides specialized assistance to pregnant women, infants and children with special health care needs through its Children's Medical Services (CMS) Program. The statewide network of 22 local CMS clinics as well as private physicians' offices, regional medical centers and medical specialty care service centers includes a range of providers not usually available through individual health plans. CMS also coordinates care with community agencies such as schools and social service agencies	Implement reviews of partnership development activities and their effectiveness	
	DOH's Health Care Practitioner and Access program improves access to health care and ensures practitioners meet licensing and practice requirements according to accepted standards of care. This program coordinates the placement of health care professionals in underserved areas through Area Health Education Centers, rural health networks and local health planning councils and expands our workforce	Improve the understanding of privacy and confidentiality laws and promote coordination across programs and system wide	
	DOH has 16,985.25 FTEs statewide and its responsibilities are outlined in Florida Statutes. There is a CHD in each of the 67 counties in Florida. DOH is a centralized organization and the CHDs are part of the department	Improve the commitment to providing sufficient resources including financial, human, leadership, technology	
	Florida's public health statutes have been recently reviewed and are keeping pace with scientific developments and current constitutional, legal and ethical changes	Implement a review of effectiveness of health communications, health education and promotion interventions	

STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

Internal to DOH (from review of NPHPS state system assessment, health status assessment, DOH Profile)	STRENGTHS	WEAKNESSES (OFIS)	Internal to DOH (from review of NPHPS state system assessment, health status assessment, DOH Profile)
	Key products and services have been identified. Customer requirements are also identified.	Implement a system-wide assurance of accurate and current content of health communications, health education and promotion interventions	
	Emerging technologies in health care including telemedicine and electronic health records create efficiencies and opportunities to expand services	Assess system wide effectiveness of efforts to reach targeted populations with culturally and linguistically appropriate health communications and resource materials	
	DOH supports pilot and demonstration projects and has many model practices that can be shared	Need to better collaborate system-wide to improve performance in informing, educating and empowering people about health issues	
	DOH purchases pharmaceuticals at federal pricing – resulting in cost avoidance	Identify a clear locus of responsibility for quality improvement for health monitoring activities	
	There are organizational processes in place that demonstrate commitment to performance management and improvement	Centralize the processing of accounts payable, HR and purchasing for CHDs	
	We have expertise in collecting, reporting and analyzing health statistics and vital records	DOH should conduct periodic reviews of effectiveness of its state surveillance systems	
	We are transitioning to electronic health records, prescriptions, lab order and transmittals	Need to improve health status and reduce disparities in chronic diseases, tobacco use, overweight/obesity, unintentional injury, prescription drug abuse, infant mortality and prematurity, unintended and teen pregnancy, breastfeeding, child abuse/neglect/adverse childhood events, oral health, depression and behavioral health, HIV, influenza, access to care, emerging health issues	
	DOH Health Management System (HMS) integrates information into a single network of systems for CHDs	Policies intended to standardize across the DOH may be too restrictive. In particular, those that hamper the ability to increase employee pay are problematic. (consider overall policy issues – are we implementing strategies in the most efficient way?)	
	CMS area offices use a satellite networking system	Implementing new technology can reduce efficiency, for example, implementing electronic health records.	
	We are able to collect and provide comparative data through DOH systems (CHARTS, Merlin, BRFSS, etc)	There's an increased demand for services without the capacity to meet the demand; resources are shrinking as a result of the economy.	
	We administer public health through 67 county health departments. They are the primary service providers in the areas of infectious disease control and prevention, family health services and environmental health services. Statewide functions such as the laboratories, Vital Statistics, a state pharmacy, and disaster preparedness and emergency operations assure efficient and coordinated approaches to monitoring diseases and responding to emerging needs at a population level		
	We have public health preparedness plans, partnerships, expertise and leadership in the health and medical component of all-hazards planning, preparation (including training and exercising), and staff and material support for potential catastrophic events that may threaten the health of citizens and compromise our ability to deliver needed health care services		

STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS

OPPORTUNITIES		THREATS	
External to DOH (from Community Themes/Strengths and Forces of Change Assessment)	Interest in workplace wellness programs	Aging population	External to DOH (from Community Themes/Strengths and Forces of Change Assessment)
	Recruitment of health care practitioners	Decreasing insurance coverage	
	Re-assess, re-evaluate health care practitioner assessments that DOH performs	Fewer benefits for workers	
	Educate public and policy makers about public health	No payor source for oral health care	
	Expand use of model practices	Shortage of health care providers	
	Participation in proposing changes to regulations	Emerging geographic health care shortage areas	
	Include partners in planning, assessments including hospitals, local health councils, environmental health, and planning organizations	Program and funding cuts shift burdens to other segments of the public health system	
	Use effective, evidence-based strategies and model practices	Health issues: obesity, diabetes, tobacco use, oral health, prescription drug abuse, lack of physical activity, physical, adult substance abuse, teen pregnancy	
	Include health impact assessments in planning	Funding cuts	
	Certificate of need process	Increased need for behavioral health services	
	Telemedicine use to expand services	Increased demands for care due to demographic shifts and economic situations	
	Most adult Floridians report having a good quality of life	Overuse of Emergency Rooms for primary care	
	9 of 10 adults receive needed social support	Use of technology when leads to sedentary behavior	
	Strong networks of partners	Changes in educational practice and school curriculum impact learning healthy lifestyles	
	Public health services administered by 67 CHDs	1 in 10 adults report physical and emotional limitations	
	Specialized assistance through CMS	25% of adults are limited in their activities	
	Robust public health statutes	1 in 10 adults uses special equipment because of a health problem	
	Common priority health issues among state and locals present opportunities for system wide support and collaboration	Emerging public health threats including infectious diseases and natural disasters and concurrent complacency in terms of family and business preparedness planning.	
		Moving primary care patients to midlevel providers with little quality control over providers' practicum experiences	
		Lack of residency slots for practitioners educated in Florida	
		No reciprocity for dental licenses in Florida.	
		Inconsistent behavioral health services across counties.	

APPENDIX C:

DOH AGENCY STRATEGIC PLAN ALIGNMENT WITH STATE HEALTH IMPROVEMENT PLAN AND NATIONAL/STATE GOALS/ OBJECTIVES/MEASURES

AGENCY STRATEGIC PLAN OBJECTIVE NO.	AGENCY STRATEGIC PLAN OBJECTIVE	SHIP ALIGNMENT	SHIP GOAL, STRATEGY OR OBJECTIVE	OTHER ALIGNMENT
1.1.1.A	By Dec. 31, 2015, increase the percentage of two-year-olds who are fully immunized from 86.6% (2011) to 90%.	HP1.1.1	By Dec. 31, 2015, increase the percentage of two-year-olds who are fully immunized from 86.6% (2005) to 90%.	PAHPA Benchmark Measure
1.1.1.B	By Dec. 31, 2015, reduce the bacterial STD case rate among females 15-34 years of age from 2627.3 per 100,000 (2010) to 2605 per 100,000.	HP1.2.1	By Dec. 31, 2013, reduce the bacterial STD case rate among females 15-34 years of age from 2627.3 per 100,000 (2010) to 2620 per 100,000.	HP2020, DOH Long Range Program Plan
1.1.1.C	By Dec. 31, 2015, reduce the TB case rate from 4.4 per 100,000 (2010) to 3.5 per 100,000.	HP1.2.3	By Dec. 31, 2015, reduce the TB case rate from 4.4 per 100,000 (2010) to 3.5 per 100,000.	HP2020
1.1.1.D	By Dec. 31, 2015, increase the number of identified foodborne disease outbreaks from 2.69 (2011) per million population to 3.09 per million population.	HP1.2	Prevent exposure to, and infection from illness and disease-related complications from sexually transmitted diseases (STDs), tuberculosis (TB) and other infectious diseases through educational outreach, testing, behavior change, early identification and treatment and community collaboration.	
1.1.1.E	By Dec. 31, 2015, reduce the AIDS case rate per 100,000 from 18.2 (2011) to 17.2.	HP1.3.1	By Dec. 31, 2015, reduce the AIDS case rate per 100,000 from 21.8 (2010) to 20.5.	HP2020, DOH Long Range Program Plan
1.1.1.F	By Dec. 31, 2015, reduce the number of new HIV infections in Florida from 4,577 (2009) per year to 2,778 per year with particular focus on the elimination of racial and ethnic disparities in new HIV infections.	HP1.3.4	By Dec. 31, 2015, reduce the number of new HIV infections in Florida to be at or below the national state average per year with particular focus on the elimination of racial and ethnic disparities in new HIV infections.	HP2020
1.1.1.G	By Dec. 31, 2013, increase the number of selected reportable disease cases of public health significance reported from CHDs within 14 days of notification to greater than 75%.	HP1.4.1	By Dec. 31, 2015, increase the percentage of currently enrolled AIDS Drug Assistant Program (ADAP) clients with suppressed viral load from 85% (2010) to 90%.	
1.1.1.H	By March 31, 2013, conduct a CHD consortia-level assessment of the current tuberculosis control program and recommend program priorities and resource allocation.	HP1.2	Prevent exposure to, and infection from illness and disease-related complications from sexually transmitted diseases (STDs), tuberculosis (TB) and other infectious diseases through educational outreach, testing, behavior change, early identification and treatment and community collaboration.	

AGENCY STRATEGIC PLAN OBJECTIVE NO.	AGENCY STRATEGIC PLAN OBJECTIVE	SHIP ALIGNMENT	SHIP GOAL, STRATEGY OR OBJECTIVE	OTHER ALIGNMENT
1.1.1I		HP1.2	Prevent exposure to, and infection from illness and disease-related complications from sexually transmitted diseases (STDs), tuberculosis (TB) and other infectious diseases through educational outreach, testing, behavior change, early identification and treatment and community collaboration.	
1.1.1J	By Dec. 31, 2015, increase by 10% the proportion of reports of selected reportable diseases for which initial public health control measure(s) were initiated within the appropriate time frame (as defined by the standard established in the CHD Snapshot Guidance for Epidemiology Measures document).	HP1.4	Conduct disease surveillance to detect, monitor and collect data for public health program planning, evaluation and policy development.	
1.1.1K	By Dec. 31, 2014, develop a plan that enables interoperability across appropriate disease surveillance systems.	HP1.4	Conduct disease surveillance to detect, monitor and collect data for public health program planning, evaluation and policy development.	
1.1.2A	By Sept. 30, 2013, and annually ensure that 90% of illness outbreaks associated with a regulated facility have an environmental assessment or inspection done within 48 hours of initial outbreak report.	HP2.2.1	By Sept. 30, 2012, and annually ensure that 90% of illness outbreaks associated with a regulated facility have an environmental assessment or inspection done within 48 hours of initial outbreak report.	
1.1.2B	By Dec. 31, 2014, 100% of Florida counties will complete the Environmental Public Health Performance assessment, use data to determine gaps and opportunities and create health plans.	HP2.1.1	By Dec. 31, 2014, 100% of Florida counties will complete the Environmental Public Health Performance assessment, use data to determine gaps and opportunities and create action plans.	
1.1.3A	By Dec. 30, 2013, the score for each CHD that meets or exceeds the CHD preparedness expectations shall be at least 4.75.	HP3.2	Ensure that systems and personnel are available to effectively manage all hazards.	
1.1.4A	By Dec. 31, 2015, reduce the rate of deaths from all causes of external injury among Florida resident children ages 0–14 from 9.0 per 100,000 to 7.6 per 100,000 in those Florida counties with existing state-local injury prevention partnerships with their local Safe Kids chapter or coalition (includes Bay, Marion, Osceola, Lake, Sumter, Okaloosa, Santa Rosa, Leon, Broward, Dade, Tampa, Lee, Collier, Alachua, Bradford, Columbia, Dixie, Gilchrist, Levy, Suwannee, Union, Orange, Baker, Clay, Duval, Nassau, Putman, St. Johns, Palm Beach, Seminole, Pasco, Pinellas, Polk, Manatee, Sarasota, Volusia, Flagler).	HP4.1.3	By Dec. 31, 2015, reduce the rate of deaths from all causes of external injury among Florida resident children ages 0–14 from 9.0 per 100,000 to 7.6 per 100,000 in those Florida counties with existing state-local injury prevention partnerships.	DOH Long Range Program Plan, National Prevention Strategy, CDC's Winnable Battles

AGENCY STRATEGIC PLAN OBJECTIVE NO.	AGENCY STRATEGIC PLAN OBJECTIVE	SHIP ALIGNMENT	SHIP GOAL, STRATEGY OR OBJECTIVE	OTHER ALIGNMENT
1.1.4B	By Dec. 31, 2015, decrease the rate of death from falls among persons aged 65 and over in Florida from 59.7 per 100,000 (2011) to 50.	HP4.1.1	By Dec. 31, 2012, Develop a senior falls prevention plan.	
1.1.4C	By Dec. 31, 2015, decrease the rate of death from unintentional injury in Florida from 40.2 per 100,000 (2011) to 38.	HP4	Prevent and reduce unintentional and intentional injuries.	
1.2.1A	By Dec. 31, 2015, increase the percentage of adults who have a healthy weight from 34.9% (2010) to 40.0% (healthy weight is BMI of 18.5 to 24.9).	CD1	Increase the percentage of adults and children who are at a healthy weight.	HP2020, CDC's Winnable Battles
1.2.1B	By Dec. 31, 2015, decrease the percentage of WIC children aged 2 and above who are overweight or at risk of overweight from 29.5% (2010) to 28.5%.	CD1	Increase the percentage of adults and children who are at a healthy weight.	HP2020, CDC's Winnable Battles
1.2.1C	By Dec. 31, 2015, increase the percentage of students in grades 1,3, and 6 who are identified as being at normal weight from 60% (2011-2012) to 63%.	CD1	Increase the percentage of adults and children who are at a healthy weight.	HP2020, CDC's Winnable Battles
1.2.1D	By Dec. 31, 2015, decrease the percentage of students in grades 6-12 reporting BMI at or above the 95th percentile from 11.6% (2010) to 10%.	CD1	Increase the percentage of adults and children who are at a healthy weight.	HP2020, CDC's Winnable Battles
1.2.2A	By Dec. 31, 2014, reduce current smoking rates among adults from 17.1% (2010) to 14.5%.	CD4.2.1	By Dec. 31, 2014, reduce current smoking rates among Florida adults from 17.1% (2010) to 14.5%.	HP2020
1.2.2B	By Dec. 31, 2015, reduce current cigarette use among youth, ages 11-17, from 8.3% (2010) to 7.5%.	CD4.2.3	By Dec. 31, 2015, reduce current cigarette use among Florida's youth, ages 11-17 from 8.3% (2010) to 7.5%.	
1.2.2C	By Dec. 31, 2015, reduce the percentage of adults who were exposed to secondhand smoke at home during the past 7 days from 8.6% (2010) to 7.7%.	CD4.3.1	By Dec. 31, 2015, reduce the percentage of Florida adults who were exposed to secondhand smoke at home during the past 7 days from 8.6% (2010) to 7.7%.	HP2020
1.2.2D	By Dec. 31, 2015, reduce the percentage of youth, ages 11-17, who were exposed to secondhand smoke in a room or car during the past 7 days.	CD4.3.2	By Dec. 31, 2015, reduce the percentage of Florida youth, ages 11-17 that were exposed to secondhand smoke in a room or car during the past 7 days from 50.3% (2010) to 45.3%.	HP2020
1.2.2E	By June 30, 2015, reduce the percentage of youth, ages 11-17, who use tobacco products *other than cigarettes from 14.1% (2010 Florida Youth Tobacco Survey) to 12.7%.*Other tobacco products include smokeless tobacco, snus, and cigars	CD4.2.4	By Dec. 31, 2015, reduce the use of tobacco products other than cigarettes by youth, ages 11-17, from 14.1% (2010) to 12.7%. Tobacco products include: smokeless tobacco, snus, cigars, flavored cigars, bidis, kreteks, pipe tobacco, flavored tobacco and hookah.	HP2020

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1.2.2F	By June 30, 2015, reduce the percentage of adults who use tobacco products *other than cigarettes from 5.6% (2008 BRFSS) to 4.76%. *Other tobacco products include smokeless tobacco, snus, and cigars	CD4.2.2	By Dec. 31, 2015, reduce the use of other tobacco products—smokeless tobacco, snus (pouched smokeless tobacco) and cigars—among Florida adults from 5.6%	HP2020
1.3.1A	By June 30, 2013, 100% of CMS area offices will collaborate with Department of Children and Families in the provision of care coordination services for children in out-of-home care who meet the clinical eligibility criteria for the CMS Network.	AC6.1.1	By June 30, 2013, 100% of the Children's Medical Services area offices will collaborate with the Department of Children and Families in the provision of care coordination services for children in out-of-home care who meet the clinical eligibility criteria for the Children's Medical Services Network.	HP2020, DOH Long Range Program Plan
1.3.1B	By December 31, 2015, increase the percentage of 8-year-old Medicaid-eligible children who have received dental sealants on their molar teeth from 14% (2010) to 17%.	AC4.3.2	By Dec. 31, 2015, increase the percentage of children and adolescents who have received dental sealants on their molar teeth.	HP2020
1.3.2A	By Dec. 31, 2015, reduce the infant mortality rate from 6.4 (2011) per 1,000 live births to 6.1.	AC5.4.3	By Dec. 31, 2015, reduce the infant mortality rate from 6.5 (2010) to 6.1 per 1000 live births.	HP2020, National Prevention Strategy, DOH Long Range Program Plan
1.3.2B	By Dec. 31, 2015, reduce the black infant mortality rate from 12.0 (2011) per 1,000 live births to 10.9.	AC5.4.4	By Dec. 31, 2015, reduce the black infant mortality rate from 11.8 (2010) to 10.9 per 1000 live births.	HP2020, National Prevention Strategy, DOH Long Range Program Plan
2.1.1A	By June 30, 2013, DOH will complete statewide implementation of the Master Patient Index system.	HI1.2	Promote provider adoption of certified electronic health record software	HP2020
2.1.1B	By Dec. 31, 2013, DOH will begin the pilot phase of implementation of the Health Information Exchange (HIE), which consists of a statewide Master Patient Look-up function across all CHDs and public health surveillance systems and the ability to exchange patient clinical data both internally and with external community partners.	HI1.2.5	By Dec. 31, 2012, DOH will launch a certified electronic health record for county health departments.	HP2020
2.1.2A	By Nov. 30, 2012, DOH will complete certification of the HMS electronic health record for county health departments.	HI1.2	Promote provider adoption of certified electronic health record software	HP2020
2.1.2B	By June 30, 2013, all CHD clinical sites will have adopted the DOH certified Electronic Health Record.	HI1.2.6	By Dec. 31, 2013, county health department clinical providers in all 67 counties will be using DOH certified electronic health records in accordance with criteria established by the Federal Office of National Coordination.	HP2020

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2.1.3A	By Jan. 1, 2013, increase the percentage of reportable disease case reports where the department received electronically submitted laboratory reports to 65%.	HI1.3.2	By Jan. 1, 2013, increase the percentage of reportable disease case reports where the department received electronically submitted laboratory reports to 65%.	Electronic Health Record Incentive Program
2.1.3B	By Dec. 31, 2013, increase the number of hospitals and urgent care centers submitting electronic information used for syndromic surveillance to DOH from 170 to 185.	HI1.3.3	By Dec. 31, 2013, increase the number of hospitals and urgent care centers submitting electronic information used for syndromic surveillance to DOH from 170 to 185.	Electronic Health Record Incentive Program
2.1.3C	By Jan. 1, 2015, DOH will be using the statewide health information exchange to support public health case reporting and epidemiological case follow-up.	HI1.3.4	By Jan. 1, 2015, DOH will be using the statewide health information exchange to support public health case reporting and epidemiological case follow-up.	Electronic Health Record Incentive Program
2.1.5G	By January 31, 2014, implement an automated system for completion of employee performance appraisals.	HI3.4.4	By July 1, 2014, the percentage of employees who have had an Employee Development Plan completed during their performance appraisal will increase from 19.5% to 30%.	
2.2.1A	By July 1, 2013, implement a revised Medicaid reduction methodology for cost-based providers in the General Appropriation Act and apply DOH efficiency standards to CHD rates.	HI2.1.3	By Oct. 1, 2012, a revised Medicaid reduction methodology for cost-based providers will be implemented in the General Appropriations Act and DOH efficiency standards will be applied to CHD rates.	
2.2.1B	By Dec. 1, 2015, implement the CHD Health Management System Billing Redesign Project to automate all major billing functions and establish 100% electronic interaction with health care plans.	HI2.1.4	By Dec. 1, 2015, the CHD Health Management System Billing Redesign Project to automate all major billing functions and establish 100% electronic interaction with health care plans will be implemented.	
2.2.1C	By Sept. 1, 2013, implement a third-party billing administrator function to automate claims payment and other programmatic support services for Children's Medical Services.	HI2.1.5	By April 30, 2013, Children's Medical Services will have implemented a third party billing administrator function to automate billing functions.	
2.2.2A	By Dec. 1, 2013, and annually, complete process to analyze all state and local fees to ensure alignment with actual program costs.	HI2.3.2	By Dec. 1, 2012, all CHDs will have documented a fee analysis or fee adjustment process to better align fees with actual cost.	

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2.2.2B	By March 1, 2013, develop a standard methodology for calculating the cost of specific medical and dental procedures weighted by relative value units for the major county health department clinical programs.	HI2	Assure adequate public health funding to control infectious diseases, reduce premature morbidity and mortality due to chronic diseases, and improve the health status of residents and visitors.	
2.3.1A	By December 31, 2015, implement the components of a sustainable performance management system.	HI4	Promote an efficient and effective public health system through performance management and collaboration among system partners.	
2.3.2A	By Dec. 31, 2013, DOH's performance management data system will be operational.	HI4.3.9	By Dec. 31, 2013, DOH's performance management data system will be operational.	HP2020
2.3.2B	By June 30, 2014, DOH will be accredited by the Public Health Accreditation Board.	HI4.3.4	By Jan. 31, 2015, 31 CHDs will be accredited by the Public Health Accreditation Board.	HP2020
2.3.2C	By Dec. 31, 2013, complete a comprehensive management review of 100% of Children's Medical Services area offices to ensure continuous improvement efforts related to the processes and functions of the Children's Medical Services Network.	HI4.3.5	By Dec. 31, 2013, 100% of Children's Medical Services' area offices will have gone through a comprehensive management review to ensure continuous improvement efforts related to the processes and functions of the Children's Medical Services Network.	
3.1.1A	By Jan. 1, 2013, and every year thereafter, conduct a statewide safety net primary health care provider assessment.	AC1.1.1	By Dec. 31, 2012, and every four years thereafter to coincide with the state health improvement planning process, a health resource assessment process will be conducted resulting in a written report that includes an inventory, analysis and geographic mapping of Florida's health care providers including high-volume Medicaid providers, health care needs of Florida residents, and health insurance coverage.	Public Health Accreditation Board
3.1.1B	By July 1, 2013, each CHD in conjunction with local coalitions will develop a written plan to address the county's safety net primary health care needs. The plan should address primary care and oral health roles in the community based on the assessment completed in objective 3.1.1A and will be updated annually.	AC1	Regularly assess health care assets and service needs.	

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3.1.2A	By June 30, 2014, implement a Culturally and Linguistically Appropriate Services (CLAS) self-assessment tool.	AC7.1.2	By June 30, 2013, DOH will facilitate development of a self-assessment of CLAS that can be used across many provider settings.	HP2020, National Prevention Strategy
3.2.1A	By March 31, 2013, all CHDs will have produced a current (within the past 5 years) community health improvement plan.	HI4.1.1	By Dec. 31, 2013, 100% of counties will have produced a current (within the past 3–5 years) community health improvement plan.	HP2020, Public Health Accreditation Board
3.2.1B	By March 31, 2013, all state and local health improvement plans will be aligned.	HI4.1.2	By Dec. 31, 2015, 100% of community health improvement plans will be aligned with the goals and strategies in the State Health Improvement Plan.	HP2020, Public Health Accreditation Board
3.2.1C	By Jan. 31, 2013, and regularly thereafter, convene to assess State Health Improvement Plan (SHIP) progress with partners.	HI4.2.1	By Jan. 31, 2013, State Health Improvement Plan partners will convene to discuss progress of plan implementation.	Public Health Accreditation Board
3.2.2A	By Dec. 31, 2014, increase public health presence in the local planning process by ensuring all county health departments will attend a minimum of one county planning board, planning review committee, or regional planning meetings.	CR1.1.2	By Dec. 31, 2014, all county health departments will have public health attendance in their community planning processes with each of the 67 county planning boards.	
3.2.2B	By July 31, 2013, the DOH state office will establish a mechanism for sharing data and information from the local county health departments about community assessment work across organizations.	CR1.3.2	By July 31, 2013, DOH will establish a mechanism for sharing data and information about community assessment work across organizations.	
3.2.3A	By Oct. 31, 2013, DOH will forge partnerships with HUD and other local, regional and federal funding agencies to develop a model program for improving housing conditions for vulnerable populations.	CR2.1.4	By Oct. 31, 2013, DOH will forge partnerships with HUD and other local, regional and federal funding agencies to support “Moving to Opportunity” which improves housing conditions for vulnerable populations.	DOH Healthy Homes Consortium
4.1.1A	By Dec 31, 2015, 95% of position descriptions will include competencies aligned to agency core competencies framework.	HI3	Attract, recruit and retain a prepared, diverse and sustainable public health workforce in all geographical areas of Florida.	

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4.1.1B	By Dec 31, 2015, 80% of employees will have documented Employee Development Plans which identify competency-based training.	HI3.4.4	By July 1, 2014, the percentage of employees who have had an Employee Development Plan completed during their performance appraisal will increase from 19.5% to 30%.	
4.1.2A	By Dec 31, 2015, deliver and evaluate competency-based certificate programs for public health employees.	HI3	Attract, recruit and retain a prepared, diverse and sustainable public health workforce in all geographical areas of Florida.	
4.1.2B	By Dec 31, 2015, evaluate effectiveness of lifelong learning opportunities in developing core competencies.	HI3	Attract, recruit and retain a prepared, diverse and sustainable public health workforce in all geographical areas of Florida.	
4.2.1A	By June 30 of each year, 95% of activities identified in Agency Workforce Development Plan are complete based on established schedule.	HI3.4.2	By July 1, 2013, DOH will achieve a minimum of two objectives in each of the goal areas of the Workforce Development Plan.	

APPENDIX D:
COUNTY HEALTH DEPARTMENT ALIGNMENT DOCUMENTATION